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AMERICANS AT RISK: THE CASE OF THE MEDICALLY UNINSURED

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JUNE 27, 1985

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AMERICANS AT RISK: THE CASE OF THE MEDICALLY UNINSURED

THURSDAY, JUNE 27, 1985

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The special committee convened, pursuant to notice, at 9:05 a.m., in room SD-628, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Chiles, Warner, Dodd, Grassley, and Glenn.

Staff present: Stephen McConnell, staff director; Robin Kropf, chief clerk; Diane Lifsey, minority staff director; Beth Fuchs, professional staff member; Jane Jeter, minority professional staff member; Betsy Vierck, research analyst; Paul Steitz, professional staff member; Isabelle Claxton, communications director; Sara White, communications deputy; Kimberly Kasberg, staff assistant; Lucy Savidge, legislative correspondent; Dan Tuite, printing assistant; and Chris Jennings, legislative correspondent.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. The special committee will come to order. Good morning, ladies and gentlemen. Today the subject of our hearing is "Americans at Risk: The Case of the Medically Uninsured."

For one in six Americans today, riding in a car, catching a cold, just getting out of bed a day older each morning poses a monumental risk. There are 35 million citizens without health insurance for whom an accident or illness carries the threat of financial disaster, unnecessary pain, disability, and even death.

America's medically uninsured represent a broad cross-section of income class, employment status, and age groups. They are managers of small offices without company insurance; unemployed workers without the cash to carry an individual policy; early retirees, too young for Medicare, but too poor or too sick to obtain private insurance.

The ranks of the uninsured in this country swelled by more than 20 percent between 1979 and 1983. Economic recession exacerbated this trend, no doubt, but recovery has not reversed the tide.

As chairman of the Special Committee on Aging, I am particularly alarmed that almost 3 million people aged 55 to 64 are at risk without insurance. This group, in what we call the "pre-golden years," suffer accelerating health problems, and it can be a long and expensive wait until Medicare benefits kick in at age 65.

Other distinct groups of Americans at great risk of inadequate care are widows and divorced women; women aged 55 to 64 who have never married, and individuals with a pre-existing illness.

Traditionally, Americans insure themselves against the financial risk of poor health through four major avenues. The first, and by far the largest, is employer-sponsored group health insurance. The second is Medicare, the health insurance program for almost 30 million retired and disabled citizens. Medicaid, the third avenue, limits coverage to the very poor elderly, disabled, and single-parent families. Fourth is private insurance paid for by the individual.

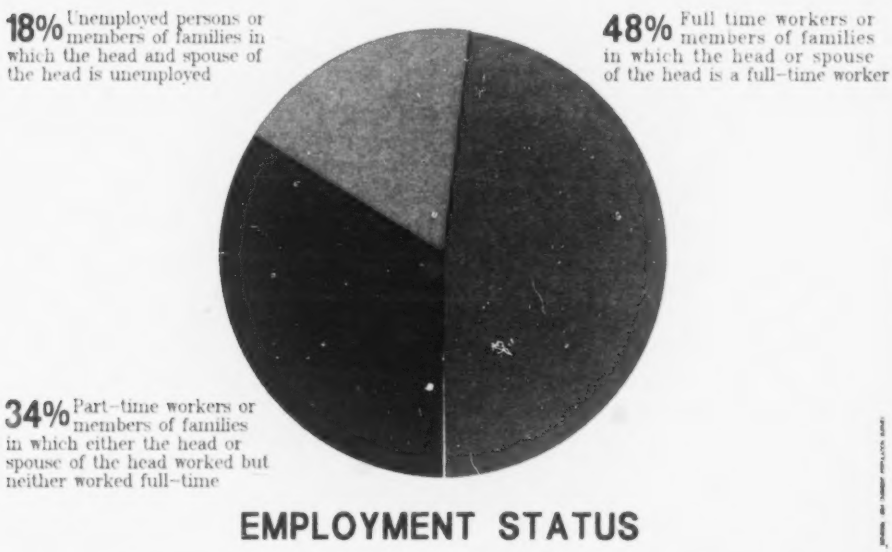
Four avenues for care, but each with insurmountable roadblocks for too many in need of insurance.

As the first two charts illustrate, neither a job nor a comfortable income guarantee a safe passage.

Chart 1 shows that workers with full- or part-time jobs and their dependents make up almost two-thirds of the near-elderly without insurance.

CHART 1

WHO ARE THE MEDICALLY UNINSURED?

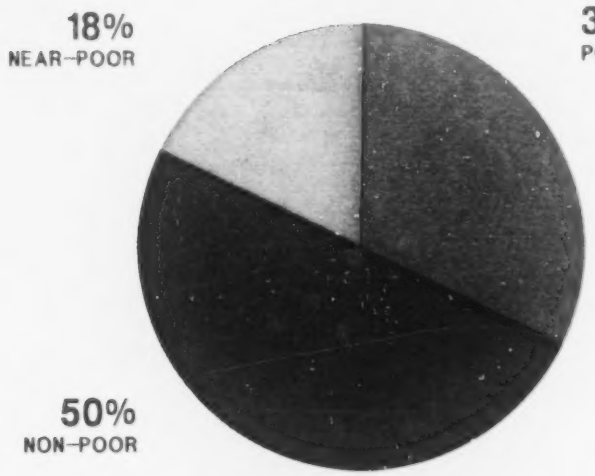

18% Unemployed persons or members of families in which the head and spouse of the head is unemployed
48% Full time workers or members of families in which the head or spouse of the head is a full-time worker
34% Part-time workers or members of families in which either the head or spouse of the head worked but neither worked full-time

EMPLOYMENT STATUS

On chart 2, we see that over half of the uninsured Americans between 55 and 64 years of age are middle-income who, if faced with a severe medical problem, could become impoverished.

CHART 2

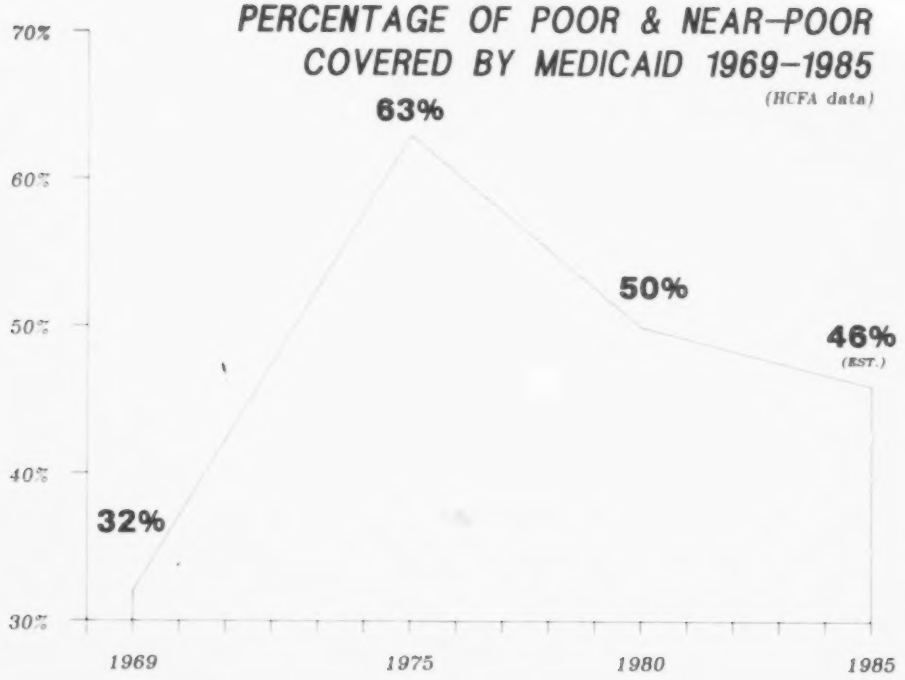
WHO ARE THE MEDICALLY UNINSURED?



POOR/NON-POOR

While the need for help has increased, the main source of public aid, Medicaid, has been severely cut back at both the Federal and State levels. As chart 3 illustrates, in 1985, less than half of those Americans below or hovering just above the poverty level are being covered by Medicaid.

CHART 3



With pressures of competition and cost control continuing to build, health care providers are increasingly hard-pressed to provide the free services so critical for the care of the uninsured.

Can America condone a conveyor-belt system of care where the uninsured are moved from hospital to hospital and finally dumped at the door of an overcrowded, often understaffed, public facility? Should those providers, who by law must provide free care, bear the burden for the rest of society? Has the right to quality care, held forth to all Americans, become the privilege of the wealthy few?

As a nation, it is my judgment we must do much better than that.

Our witnesses today will help identify the economic and public policy factors pushing up the number of uninsured. I look forward very much to what they have to say, to their analyses and ideas, and hopefully, their solutions.

Today, I want to announce that I will be introducing legislation aimed at filling at least a small part of the gaping hole in this Nation's health insurance system. The Health Insurance Availability Act of 1985 would provide incentives for States to form an insurance pool, a fund to help the otherwise uninsurable obtain the high-cost coverage that they need.

I must confess that I think this is a small finger in the dike, and does not solve in any way nearly all the problems that the uninsured have, but it can help hold back the flood of uninsured Ameri-

cans at least in part, until more comprehensive changes are in place.

Senator HEINZ. I would like to welcome our first three witnesses. I would ask that Elizabeth Morrison, Beulah Shuffler, and Margaret DiLombard please come forward and take your places at the witness table.

Before we start, I would like to recognize one of the most active members of this committee, a man who also on his other committee, the Human Resources Committee, in past years has chaired a subcommittee that also deals with the problems of the elderly, my friend and colleague from Iowa, Senator Chuck Grassley.

Chuck, if you have an opening statement, please proceed.

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. I want to say that I do have a statement to put in the record. I want to publicly compliment you on this very meaty issue that you are getting into, particularly in my State, where we are still in real economic depression as a result of the depressed farm economy. The medical needs of people are particularly severe. My State has the third-highest population of elderly, percentage of elderly, and so I am very much interested in it from that point of view.

So I will not take any further time, but I thank you for holding the hearing, and particularly thank you for letting me have some input on the agenda.

Chairman HEINZ. Thank you, Senator Grassley. Without objection, your statement will be made a part of the record in full.

I thank you for being here, because you do such a good job serving your citizens, your constituents in Iowa. I know, having watched you work on so many occasions, both here and in the Finance Committee, that they are very well-served.

Senator GRASSLEY. You and I seem to get in the middle of all these matters dealing with Medicare and entitlements and Social Security and so on.

Chairman HEINZ. It seems almost inevitable.

But we are not ready yet to become beneficiaries of those programs, but now that Congress is under Social Security at long last, anything is possible.

Senator GRASSLEY. Thank you, Mr. Chairman.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman. I think you and your staff are focusing on a serious problem which increasing numbers of Americans appear to be facing. This is a problem that all of us have been hearing about through our constituent mail. I have also heard about it from local officials in Iowa.

I think that it is useful and appropriate for the Special Committee on Aging to address this problem, since so many of these people are old or close to old age. I hope the committee is able to point the way to solutions to it that respect the long-established authority of the State governments in regulating the insurance industry, and have due regard to the problems we face here at the Federal level with the Federal deficit.

Thank you, Mr. Chairman. I have nothing more, and am looking forward to hearing the testimony of our witnesses.

Chairman HEINZ. Ms. DiLombard, would you please be our first witness? Please proceed.

STATEMENT OF MARGARET DiLOMBARD, JACKSON, MI

Ms. DiLOMBARD. My name is Margaret DiLombard. I am from Jackson, MI. I am 63 years old and a widow. I have a 10th grade education. I am an Alaskan Aleut Indian.

My only income now is $382 per month from Social Security and food stamps. Until last year, my health was generally good. I had tuberculosis in the 1950's, and because of that, I had part of my lung removed. And I have high blood pressure.

In the summer of 1984, I started having trouble with my sinuses. I was tired and sick but thought it was just an infection, until I started losing my hearing and I could not blow my nose.

In January of 1985, they discovered I had a tumor in the nasal pharynx. They did a biopsy in February, and discovered that it was cancer. I had been getting radiation treatments, which just ended. I had to have tubes put in my ears and had to have oral surgery because of the treatments. Now, I do not have saliva; I have no taste; I have lost 20 pounds, and my tongue hurts most of the time. It hurts for me to eat, and it takes me a long time, because my tongue is sore. I have to keep washing out my mouth.

I am thankful that the hospital would even treat me, since I have no money and no insurance. I assumed it would be covered by Medicaid. I applied for Medicaid on March 14, 1985. It was denied in April. I have requested a hearing and now I am waiting.

I am nervous most of the time. I am scared of the cancer. I am worried about the bills. I will owe about $7,000 when they all come in. My daughter died at 27 from cancer.

I am tired a lot, and cannot do as much as I used to do, and I still have headaches.

I get tired very quickly, and it is hard for me to eat. My doctor does not know when or if I can return to work because of my illness and age. My doctor does not know when my condition will improve. I am thinking about selling my home to pay the bills, but my home is all I have. I cannot afford insurance, and it would not pay for this, anyway. I am used to taking care of myself, and I want to pay my bill, but I cannot.

Chairman HEINZ. You are 63 years old, and so you are not eligible for Medicare.

Ms. DiLOMBARD. No.

Chairman HEINZ. You were turned down for Medicaid early in 1985, in March.

Ms. DiLOMBARD. Yes.

Chairman HEINZ. When will you have an opportunity to find out the result of your appeal? How long will that be?

Ms. DiLOMBARD. I do not have any idea. It just takes so long. They said 30 to 45 days, but it has been way over that, and I have not heard anything.

Chairman HEINZ. How many bills have you received from the hospital so far?

Ms. DiLOMBARD. I have not gotten my radiation bill so far, but I have gotten bills for dental treatment, the oral surgery I had,

my regular doctor, ear-nose doctor, blood tests, bone scans, and all this other stuff. It is about $688 or so.

Chairman HEINZ. At any point, did you try and obtain private health insurance? Did you try and enroll in some kind of a Blue Cross/Blue Shield policy, that kind of thing?

Ms. DILOMBARD. I have looked into some of it, but it is so expensive, I could not afford it on what income I am getting now.

Chairman HEINZ. I am going to have some more questions for you in a minute, Ms. DiLombard.

I would like to turn to Ms. Shuffler now. Ms. Shuffler, you have come all the way from San Francisco. Welcome to typical Washington weather.

STATEMENT OF BEULAH SHUFFLER, SAN FRANCISCO, CA

Ms. SHUFFLER. Thank you.

My name is Beulah Shuffler, and I am a 66-year-old widow from San Francisco, CA. My children are grown and have their own families.

Before my husband died, he was a retired electrician who had worked for a major corporation in the East. I used to do lots of volunteer work, but not for pay.

When my husband retired, his employer-provided health insurance continued to cover both of us.

In 1974, this insurance covered my bills when I discovered I had breast cancer and needed a mastectomy. In 1979, my husband died of cancer. I thought that he had left me economically secure, but when I suffered a recurrence of the cancer, I was forced to use up a lot of the savings my husband had left me to live on.

My doctors did a biopsy and prescribed chemotherapy. I thought my husband's insurance would cover me, but it was certainly a big blow to learn that it would only pay for hospitalization and not the chemotherapy, which was done on an outpatient basis. When the chemotherapy failed, the doctors prescribed radiation therapy, for which I was billed over $5,000 more. On top of these bills, I have had to pay for regular doctors' visits, blood tests, and bone scans and x rays—all from my savings, because all the private insurance companies turned me down. No insurer would risk taking on a woman with cancer in her history.

When I turned 65, I became eligible for Medicare, which covers me now, but I am still paying medical and hospital bills for the care I received before my 65th birthday.

Chairman HEINZ. A point of clarification, Ms. Shuffler. When did you actually find out that your husband's health insurance policy would no longer cover you?

Ms. SHUFFLER. About a month after he died, I had this illness. And I sent the bills away, and thought they were covered—and no way.

Chairman HEINZ. So you only found out the hard way, by having the bills returned to you.

Ms. SHUFFLER. Yes.

Chairman HEINZ. I am going to come back to you in a minute, but I do understand that you have a letter from an attorney which

explains that your husband's insurance policy did not have to cover you. Can you elaborate a little bit on that letter?

Ms. SHUFFLER. Yes. I will read from the attorney's letter.

"Note that on page 18, this medical plan was described as a welfare plan"——

Chairman HEINZ. On what page? On page 18, did you say?

Ms. SHUFFLER. Yes.

Chairman HEINZ. Page 18 of the medical plan. All right.

Ms. SHUFFLER. [Reads.]

This medical plan is described as a welfare plan and is subject to the Federal ERISA statute. What this means is that it is not technically group insurance, and therefore not subject to the New York insurance regulations, so that the conversion right contained in New York Insurance Code 480 does not apply to this plan. And ERISA, I am sorry to say, does not even address conversion rights, let alone require them. So, I am afraid you are stuck.

Chairman HEINZ. I gather you had never reviewed page 18 and the obscure legal language?

Ms. SHUFFLER. No.

Chairman HEINZ. I am not sure that anybody would know that a medical plan which is described as a welfare plan and is subject to the ERISA statute is not subject to New York State insurance regulations and conversion rights and Insurance Code Paragraph 480, and all the rest. You are not a lawyer, are you?

Ms. SHUFFLER. No, sir, Senator.

Chairman HEINZ. It sounds to me like you would have to be a super-lawyer to interpret—if you could find it—the small print on page 18, I gather.

Do you think that the insurance company treated you unfairly?

Ms. SHUFFLER. Yes, I would say that. I at least expected that I would have had—I did not expect them to go on insuring me free-of-charge, but I at least expected that I would have the conversion right.

Chairman HEINZ. Very well. I am going to have a couple more questions for you, too, but let me go to Elizabeth Morrison.

Ms. Morrison, welcome.

Ms. MORRISON. Good morning.

Chairman HEINZ. You have not had the kind of terrible experience that Ms. DiLombard and Ms. Shuffler have had, but I gather you are here because you are in the insurance industry, and you know of other people who have had similar cases.

Ms. MORRISON. That is correct, Senator, yes.

Chairman HEINZ. Would you please proceed.

STATEMENT OF ELIZABETH MORRISON, BALTIMORE, MD, VICE PRESIDENT, HERGET & CO., INC.

Ms. MORRISON. All right. Senator Heinz, Senator Grassley, thank you for the opportunity to appear before you today to speak of the problems of obtaining health insurance for older Americans.

I am Elizabeth Morrison, vice president and manager of financial services for Herget & Co., a Baltimore-based benefits compensation, consulting and risk management company. At Herget, I am in charge of individual life, disability, and health insurance.

Among numerous other volunteer activities, I currently serve on the board of directors of both the Baltimore Life Underwriters As-

sociation and the Maryland Health Underwriters Association. In addition, I have served the past 8 years as a commissioner with the Maryland Commission for Women.

As a commissioner with the Maryland Commission for Women, I am responsible for overseeing the areas of insurance and pensions. In that capacity, I am contacted regularly by women seeking help in purchasing insurance, especially health insurance. It is in my capacity as an insurance broker that I speak to you today.

Since I am a broker, I am not affiliated with any one insurance company and currently have active licenses with approximately 40 companies.

I include this background because I both write a great deal of insurance and am deeply involved in women's issues.

The area we are focusing on today is the problem older persons have in obtaining health insurance. In my profession, I see this problem most specifically in three areas: First, women who are losing their medical coverage as a result of divorce or death of their spouse; second, women who are losing their health coverage as a result of the loss of their own or their spouse's employment, and third, women who are not employed, are aged 65 or older, and yet are not eligible for medical coverage through Medicare, but cannot get coverage through private carriers. And I think we are seeing examples of this immediately with the testimony before me.

I am jumping through my written testimony, and I am moving now to the bottom of page 8.

In 1982, over 16,000 Maryland women were divorced. Of these, approximately 1,500 were over age 50, and over 3,000 women had been married 15 years or more. These women must find individual health coverage which is expensive, often unavailable, and frequently very complicated. While most plans allow for conversion without medical evidence, brief examination will quickly show that this requires the person making the conversion to pay approximately twice as much premium as before for roughly half the coverage. And conversion is, I am told, still available in only approximately half of the States in our country.

In Maryland, in November 1984, Blue Cross and Blue Shield sent out a directive. This directive said that any insured persons ineligible to remain on group coverage as a result of divorce must leave the group plan and apply for individual coverage. While it is true that persons coming off group plans must be taken by the Blues, at least in open enrollment, the problem of major medical catastrophe is still not solved. Under the Maryland Blues, the preferred and standard nongroup membership, no outpatient diagnostic or major medical benefits are available. Under their comprehensive plan, their most expensive, the maximum lifetime benefit ceiling is $25,000 for medical care not covered by their basic benefits.

In addition, they state:

> Benefits for conditions that existed on or before the effective date of the membership are available only after the membership has been in effect nine months.

To eliminate the State-by-State confusion and the extreme differences in access to coverage, I firmly believe that national legislation is needed, and I have testified on this issue already on a number of occasions. This will be especially important as more

businesses move to self-insurance and hereby remove themselves from the State medical plans' jurisdiction. And I believe that was what our second witness was referring to, and frankly, there are more of those plans every day. Our company, in fact, helps design those plans as the increase of costs gets prohibitive for many of your smaller employers.

Let me give you three specific examples of the situations I worked with this past year. The first is a woman who turned 65 years old last year. She has had a hearing problem since childhood, resulting in total loss of hearing in one ear and partial loss in the other. As a result of this problem, plus a mastectomy some 20 years ago, she had been denied health insurance by numerous private carriers. Upon reaching 65 years of age, we had hoped to get her medical coverage through Medicare, but found that she was not eligible because she had not worked enough quarters to qualify for Social Security.

She had never been married; she does not qualify under spousal benefits. After working with her for about 5 months, we were finally able to cut sufficient redtape to get her basic health coverage under the Blues during last year's open enrollment. A little over 1 month after the final placement of health care was in place, she had a heart attack. She has recovered nicely and is understandably very relieved to have had at least some medical insurance, although she still does not qualify for any major medical coverage.

I know this person well, because she is a close relative of mine. And I would add at this point, it took me 5 months to get her the coverage, and I know the intricacies of dealing with the redtape and the bureaucracy. But both the Blues and Social Security said she was not eligible because the other one had to take care of her, and of course, she was caught in the middle.

The second case is more common. In this situation, my client became divorced and therefore had to leave the basic group medical coverage she had had under her spouse's employment plan. They had been married over 20 years, and I was asked to assist in getting her medical coverage. The only problem was that in recent years, she had had severe depressions which had institutionalized her several times. As part of the divorce, her husband was more than willing to pay whatever coverage was necessary. The problem was that no insurance carrier would accept my client because of her preexistent condition. Even though she had been insured by the same company for over 20 years, this did not count for anything, because mental illness expense reimbursements usually have very limited ceilings.

I have now looked for coverage for her for over 6 months, with no success.

I would move, then, to the first of the letters that are attached in the back, which is a letter from a man whose name is Chase Ridgely.[1] Mr. Ridgely was involved in the insurance industry as an agent for a number of years, and he was also in the Army for a large part of his early employment. In 1973, he was divorced, and he was covered for health insurance under his company plan, and

[1] See Appendix p. 108.

his children were covered as was his spouse. As part of the divorce agreement, he agreed that he would continue to offer her medical coverage. His children continued to stay under his plan. What happened was, even though he continued to have a group plan, his wife now had to be covered as an individual, which cost him three times what it would previously cost, just the month before the divorce. What happened, obviously, was that there was enormous additional expense to Mr. Ridgely, but technically, there was no difference in the coverage to the company, so the company had tripled the premium for the identical coverage.

In closing, I would like to make one additional point. Many of the women we are talking about today were married at a time when they were expected to stay home and raise children. In many States, Maryland included, there have been dramatic changes in the divorce laws, and these changes have created problems retroactively. Women have been penalized for following socially acceptable patterns earlier in their lives. These women often find themselves without alimony because the court has ruled they are able to work to support themselves, and they are in good health. At best, they are often awarded what is now called rehabilitative alimony for very short periods of time.

In addition, Maryland courts often expect women to pay their own court fees and attorneys. By receiving rehabilitative alimony, the woman is not eligible for welfare, but also is not able to live up to her earlier married financial status. She is in limbo and the least likely to be able to afford the premiums of her medical coverage, and she is the least likely to be able to afford to pay for the conversion option available to her under earlier group health benefits—thereby losing forever the option to have individual health benefits without showing medical eligibility.

If she can find employment, chances are it will be part time, making her ineligible for health insurance benefits. Even if she works full time, she is frequently labeled "seasonal" or a part-time employee, to avoid the expense of adding her as an older employee to the group coverage. The very person who may have been covered for 20 to 30 years under a group health program suddenly, through a simple change in status, becomes a nonperson and in the process loses her financial protection against catastrophic illness and possible financial ruin.

One of the problems that is of great concern to me is the insurance industry's reaction to the proposed legislation. In Maryland, the lobbyists who testify before the State legislature state that legislation should be handled at the national level. These same people come to Washington and testify before Congress that this is an individual State matter and should be handled locally.

It has become a Catch-22, and it seems to me, while this balancing act goes on, the people who are hurt are the individuals, who are trying not to be a burden to their families or their Government and who are just asking to be allowed to get what so many of us already have and take for granted—basic health insurance.

Thank you.

[The prepared statement of Mrs. Morrison follows:]

PREPARED STATEMENT OF ELIZABETH S. MORRISON

Mr. Chairman and members of the Committee, thank you for the opportunity to appear before you today to speak about the problems of obtaining health insurance.

I am Elizabeth S. Morrison, Vice President and Manager of Financial Services for Herget and Company, a Baltimore-based benefits, compensation consulting and risk management company. At Herget, I am in charge of individual life, disability and health insurance. Among numerous other volunteer activities, I currently serve on the Board of Directors of both the Baltimore Life Underwriters Association and the Maryland Health Underwriters Association. In addition, I have served the past eight years as a Commissioner with the Maryland Commission for Women, most recently as a member of the Executive Committee. As a Commissioner with the Maryland Commission for Women, I am responsible for overseeing the areas of insurance and pensions. In that capacity, I am contacted regularly by women seeking help in purchasing insurance, especially health insurance. Often these women are losing their insurance as a result of a divorce, others have lost their job and cannot get health coverage and yet others have no access to medical coverage because of pre-existing health conditions. Lastly, I am a Legislative Specialist in the area of insurance for the National Federation of Business and Professional Women's Clubs/ U.S.A.

It is in my capacity as an insurance broker that I speak to you today. Since I am a broker, I am not affiliated with any one insurance company and currently have active licenses with approximately 40 companies.

I include this background because I both write a great deal of insurance and am deeply involved in women's issues.

I am sure the Committee is already aware, approximately 85% of all health insurance is obtained currently through the workplace.

I'd like to quote from Health Insurance, Coverage and Employment Opportunities for Minorities and Women, compiled by the United States Commission on Civil Rights Publication 72:

"Because most people acquire coverage through the workplace, the degree and nature of an individual's involvement in the labor force is perhaps the most important socioeconomic factor affecting the price of health insurance. In 1978, 82.3 percent of health insurance premiums purchased group policies and 17.6 percent bought individual or family policies. Thus, an examination of employment-related characteristics, such as labor force participation, occupation and industry is central to understanding the relationship of employment and health insurance because such factors are taken into account in insurance underwriting and marketing."

"An examination of insurance coverage rates by income level is also warranted because income is associated with the type of job a person has (if any) and the employment-related benefits received, including health insurance. Income also reflects, more directly, the capacity to purchase an individual policy when work-related insurance benefits are not provided or when poor health conditions result in high premium costs."

"However, because of past and present discrimination that denies equal employment opportunity, the close relationship between employment and the acquisition of health insurance contributes to creating a barrier against adequate insurance coverage for many women and racial and ethnic minorities. Compared to white males, women as well as blacks, Hispanics and other racial and ethnic minorities, are more likely to be unemployed, to be employed on a part-time basis, or to hold low-paying or seasonal jobs. Further, minorities and women are more likely to be employed in industries considered to be poor risks by the insurance industry, such as agriculture and private household services, respectively." (Page 17)

". . . Because health insurance coverage is frequently obtained through employment, unemployment presents a major obstacle to coverage. Several factors affect health insurance coverage rates for the unemployed. One is access to coverage under policies of other family members. A second is the availability of continued coverage under a group policy during a period of layoff. Another is the degree to which financial resources are available to replace group coverage with an individual policy. Because individual insurance premiums purchase fewer benefits than group insurance and because in individual coverage an employer no longer shares premium expenses, the cost of an individual policy comparable to previous group coverage may be prohibitive. In fact, no more than 10 to 14 percent of unemployed workers losing group health insurance substitute individual health insurance." (Page 19)

"Even though employed, people who do not have access to employment-related group insurance or who work less than a full work week experienced a considerable disadvantage in obtaining health insurance. Self-employed persons, who are usually

precluded from obtaining group coverage through the work place, are the least likely of all employed persons to have health insurance . . . Part-time employees are considerably less likely than full-time employees to be covered by one or more health insurance plans. The relative lack of insurance protection offered to part-time workers has a disproportionate effect on employed women because they are the majority of part-time work force." (Page 25)

"Marital status, particularly for women, also serves as an important determinant of health insurance coverage. Married women, regardless of race or national origin, are more likely to have health insurance than widowed, divorced, separated or never-married women. There are a number of reasons for these differences in coverage. Being married offers the possibility of acquiring coverage through the husband's policy if the woman herself is not employed or does not otherwise have access to group insurance. In addition, regardless of whether she works outside the home, women in husband-wife families have much higher family incomes than women who head families by themselves or women who do not live with other family members." (Page 27)

The area we are focusing on today is the problem older women have in obtaining health insurance. In my profession, I see this problem most frequently in three specific areas:

1. Women who are losing their medical coverage as a result of divorce or death of their spouse;

2. Women who are losing their health coverage as a result of the loss of their own or their spouse's employment; and

3. Women who are not employed, are 65 years or older and yet are not eligible for medical coverage through medicare but cannot get coverage through private carriers.

I'd like to address these three areas today, but first I think a little background is very important. Up until about three years ago, it was possible to purchase individual health insurance policies through insurance companies that created groups of individuals and offered them coverage through Trusts. These Trusts often required that the individual belong to a specific group or pay a yearly membership to have access to the health insurance plan. The yearly membership could be as little as $10–$25 a year.

In the past three years, most of these Trusts have either gone out of business or closed membership, making access to individual health insurance extremely difficult. The Trusts served a valuable role, but during the recent recession, many people who had put off medical attention decided to have elective care (such as a hernia operation) done while they still had access to medical insurance. Those who were not laid off often suffered stress-related health problems (ulcers, high blood pressure, etc.). The end result was that the companies insuring these Trusts and small medical plans incurred millions of dollars of claims that had not been anticipated when the rates were set. Under the plans, premiums could only be raised a certain amount per year and the plans suffered enormous losses. In many areas, plans were frozen or closed down by the state insurance commissioners because plan reserves were below the state required minimums. Persons insured under these plans either had to wait months to collect for medical expenses or found themselves paying premiums and having no reimbursement when medical bills came in. While there was no one specific area to blame that the problem occurred, the people who were hurt the most were self-employed individuals and mainly women, who had no access to alternative health protection. What this means is simply that the alternatives, which were available to persons losing group coverage, are fewer and less attractive today than several years ago.

At last count, 10 states, Maryland included, currently have insurance statutes and/or legislation that allow a person leaving employment to continue on the employer's group medical plan for a limited period of time if no other coverage is available. This time period varies by state from as little as three months to unlimited duration. In Maryland, it currently is six months. Although the regulation has been in effect for over 18 months, very few employers, and fewer employees, know it exists.

While this extension has certainly been very helpful to men and women losing their group coverage, and specifically to women losing medical coverage due to divorce, the regulation was not put into effect to solve a long-term problem. It initially was conceived as a stop-gap measure for persons losing employment during mass layoffs in the Western part of Maryland several years ago. The plan assumed that within six months, the insured (man) would be employed and have access to another set of group benefits.

The divorced woman needs medical benefits for an indefinite period of time. Obviously, if she has the availability of coverage through her place of employment, then the problem of access does not exist. However, statistics show that the woman is much more likely to be unemployed, or to be employed part-time or seasonally, where no benefits are offered.

In 1982, 16,083 Maryland women were divorced. Of these, approximately 1,500 were over age 50 and over 3,000 women had been married 15 or more years. These women must find individual health coverage, which is expensive, often unavailable and frequently very complicated.

While most plans allow for conversion without medical evidence, brief examination will quickly show that this requires the person making the conversion to pay approximately twice as much premium as before, for roughly half the coverage. And conversion is, I am told, still only available in approximately half the individual states in our country.

In Maryland, in November 1984, Blue Cross and Blue Shield sent out a directive. This directive said that any insured persons ineligible to remain on group coverage as a result of divorce must leave the group plan and apply for individual coverage. While it is true that persons coming off group plans must be taken by the Blues, at least in open enrollment, the problem of major medical catastrophe is still not solved. Under the Maryland Blues, "preferred" and "standard" non-group membership, no outpatient diagnostic or major medical benefits are available. Under their "comprehensive" plan, their most expensive, the maximum lifetime benefit ceiling is $25,000 for medical care not covered by their basic benefits. In addition, they state "Benefits for conditions that existed on or before the effective date of the membership are available only after the membership has been in effect nine (9) months." (Blue Cross/Blue Shield non-Group Program Guide 8-84)

To eliminate the state by state confusion and the extreme differences between access to coverage, I firmly believe that national legislation is needed and I have testified on this issue already on a number of occasions. This will be especially important as more businesses move to self insurance and thereby remove themselves from the state medical plans jurisdiction.

Let me give you three specific examples of the situations I have worked with this past year:

1. The first is a woman who turned 65 years old last year. She has had a hearing problem since childhood, resulting in total loss of hearing in one ear and partial loss in the other. As a result of this problem, plus a mastectomy some 20 years ago, she had been denied health insurance by numerous private carriers. Upon reaching 65 years of age, we had hoped to get her medical coverage through medicare, but found that she was not eligible because she had not worked enough quarters to qualify for social security. She has never been married, so does not qualify under spousal benefits. After working with her for about five months, we were finally able to cut sufficient red tape to get her basic health coverage under the Blues during last year's open enrollment. A little over one month after the final placement of health care was in place, she had a heart attack. She has recovered nicely and is understandably very relieved to have at least some medical insurance, although she still does not qualify for any major medical coverage. I know this person well, because she is a close relative of mine.

2. The second case is more common. In this situation, my client became divorced and therefore, had to leave the basic group medical coverage she had under her spouse's employment plan. They had been married over twenty years and I was asked to assist in getting her coverage. The only problem was that in recent years, she had had severe depressions which had institutionalized her several times. As part of the divorce, the husband was more than willing to pay for whatever coverage was necessary. The only problem was that no insurance carrier would accept my client because of her pre-existing condition. Even though she had been insured by the same company for over twenty years, this did not count for anything, because mental illness expense reimbursements usually have very limited ceilings on them. I have now looked for coverage for her for over six months with no success.

3. Case number 3 involved a woman who divorced several years ago but was able to find employment and therefore, was eligible for health coverage under her company's plan. Early last year, her company cut back employees and she was laid off. Panicked, she called me to help her find medical coverage. Because during the divorce she had seen a psychologist for sessions lasting over a period of about a year's time, she was considered "emotionally unstable" by insurers and with this pre-existing condition, total coverage was unavailable to her. Fortunately, she was able to use the six month extension available under Maryland's new insurance regulations and during this period of time she found a new job. The company she went with was

very small and almost everyone had insurance through their spouse, so no company plan was in existence. In the past month, this company has changed its procedures and has now made arrangements to cover their employees, mainly to assist her in getting the coverage she needs so much. This is an unusual case of a very sympathetic employer who happens to know first-hand how important broad medical coverage can be.

I could continue with numerous additional cases, but in the interest of time, I will include specific written testimony of five persons who spoke before the Maryland Legislature on this issue four (4) months ago.

In closing, I would like to make one additional point. Many of the women we are talking about today were married at a time when they were expected to stay home and raise children. In many states, Maryland included, there have been dramatic changes in the divorce laws and these changes have created problems retroactively. Women have been penalized for following socially acceptable patterns earlier in their lives. These women often find themselves without alimony because the court has ruled they are able to work to support themselves and in good health. At best, they are often awarded what is now called "rehabilitative alimony" for very short periods of time. This often translates into a few hundred dollars a month for a period of only several years. In addition, Maryland courts often expect women to pay their own court fees and attorneys.

By receiving rehabilitative alimony, the woman is not eligible for welfare, but also is not able to live at her earlier married financial status. She is in limbo; she is the least likely to be able to afford the premiums for her medical coverage and she is the least likely to be able to afford to pay for the conversion option available to her under her earlier group health benefits, thereby losing, forever, the option to have individual health benefits without showing medical eligibility.

If she can find employment, chances are it will be part-time, making her ineligible for health insurance benefits. Even if she works full-time, she is frequently labeled "seasonal" or a "part-time" employee to avoid the expense of adding her as an older employee to the group coverage. The very person who may have been covered for 20–30 years under a group health program suddenly, through the simple change of status, becomes a non-person, and in the process, loses her financial protection against catastrophic illness and possible financial ruin.

One of the problems that is of great concern to me is the insurance industry's reaction to the proposed legislation. In Maryland, the lobbyists who testify before the state legislature state that legislation should be handled at the national level. These same people come to Washington and testify before Congress that this is an individual state matter and should be handled locally. It has become a "Catch 22" and it seems to me, while this balancing act goes on, the people who hurt are the individuals who are trying not to be a burden to their families or their government and who are just asking to be allowed to get what so many of us already have and take for granted—basic health coverage.

Chairman HEINZ. Ms. Morrison, thank you very much. I will come back to you in a minute.

I want to first make an announcement. Senator Grassley, who was here earlier, and who spoke briefly, had to leave to chair another hearing in the Senate Finance Committee that began at 9:30, and he wanted me to convey to you his regrets. But Senator Packwood, who is the chairman of the Finance Committee, is occupied on the floor with legislation, and so Senator Grassley had to chair the Finance Committee hearings on tax reform.

I am pleased however to note the presence of another very valuable member of this committee, Senator Chris Dodd of Connecticut. And I would observe—although he does not know, I guess, that I am going to make this comment—he, of course, being from Connecticut, has to be an expert on the insurance industry, because they all started there, I guess. Even one of Pennsylvania's largest insurance companies merged a few years ago with a Connecticut-based company to become CIGNA.

Senator Dodd has also been extremely active—I serve with him on the Banking Committee—in trying to make sure that we do have a strong, viable insurance industry. So it is a pleasure to ask

him at this time if he has any opening statement he would like to make.

STATEMENT BY SENATOR CHRISTOPHER J. DODD

Senator DODD. Well, I thank you very much, Mr. Chairman, and let me first of all commend you for holding today's hearing and inviting our panels of witnesses and to focus on an issue which is growing in its proportions and is timely. Like so many other people with conflicts in terms of various other committee assignments, it is unfortunate that we do not get the kind of full participation we would like to have, but this is going to serve as a very important record, I think, as we begin to examine potential legislative responses to the problem.

As you certainly are aware, over the past few years, we have witnessed a dangerous increase in the number of medically uninsured Americans. The recent recession, high unemployment rates, cutbacks in Medicaid and other programs, and increase in the number of self-insured employers who provide limited or postretirement benefits, all have contributed to this alarming trend.

In 1983, at least 13 percent of all Americans, about 29 million people, lacked any form of health care coverage. This figure represents a 16-percent increase over 1979, when 25 million of our citizens were without health insurance.

Unfortunately, while the number of uninsured Americans is on the rise, the ability of hospitals to absorb the costs of their care has also waned. Recently imposed Medicare reimbursement caps and increased competition among health care providers has severely limited the ability of hospitals to finance uncompensated care by shifting costs to the public and private third-party insurers.

As a result, hospitals often deny uninsured individuals access to emergency room care, require large deposits before care is provided or—and I use the word here in quotations—"dump" individuals from hospital to hospital, until one finally agrees to provide charity care.

I realize that hospitals do not engage in these practices voluntarily, and I certainly would hope that our committee would consider policy alternatives which could help alleviate this problem.

I am also concerned about the 3 million Americans aged 55 to 64 who have no form of health care coverage at all. Many have lost their jobs, and thus their employer-sponsored insurance, but cannot afford the premiums associated with private insurance plans. Others are early retirees who either cannot afford private insurance or cannot obtain an individual policy because of the preexisting illnesses or impairments. And yet, no matter how or why they lose access to coverage, these individuals remain ineligible for Medicare because they are not age 65. Now, this gap in coverage comes at an age when the risk of illness increases, a time when accident or prolonged illness could become a crippling financial burden.

I am, therefore, very pleased, Mr. Chairman, that today's hearing will focus on these so-called near-elderly citizens and what their lack of coverage means for our growing population of older Americans. In my view, there is much that can be done at the State and Federal levels to improve the access of uninsured Ameri-

cans to adequate health care. In my own State of Connecticut, we have established an assigned risk pool from which individuals can buy health insurance at reasonable standard rates. While this system does not address the needs of indigent uninsured, it does provide coverage for those who cannot obtain private insurance because of preexisting medical conditions.

Representative Barbara Kennelly, I might add, from Connecticut, has sponsored legislation in the House which would encourage other States to set up similar pools, and I understand that you, Mr. Chairman, will soon be introducing a companion measure in the Senate. I hope, certainly, our witnesses will feel free to comment on the merits of the risk pool concept as well as other States' efforts to provide coverage to individuals and reimbursement to health care providers. The dialog that we establish here today can go a long way toward helping policymakers at all levels meet the needs of our Americans at risk.

Mr. Chairman, I might add that, like everyone else, I suppose, we all have personal experiences of one kind or another, but a person that works for me in my Connecticut office had a child, and they were not covered, and no insurance. The child was born with severe medical problems. The child is now 5 years old—and doing fine, I might add—but the infant spent the first 8 months of her life in the hospital, and that hospital bill without any insurance was close to $100,000. And they will never, ever, ever pay off that bill, because they just were not covered. He was unemployed at the time and did not have it, and so they are right from the very outset saddled with a financial burden they just cannot crawl out from underneath. And there are hundreds of stories like that.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR CHRISTOPHER J. DODD

I would like to thank the distinguished chairman of our committee, Senator Heinz, for organizing today's hearing on "Americans at Risk: the Case of the Medically Uninsured."

Over the past few years, we have witnessed a dangerous increase in the number of medically uninsured Americans. The recent recession, high unemployment rates, cutbacks in Medicaid and other programs, and an increase in the number of self-insured employers who provide limited or no post-retirement benefits, have all contributed to this alarming trend. In 1983, at least 13 percent of all Americans — about 29 million people — lacked any form of health care coverage. This figure represents a 16 percent increase from 1979 when 25 million of our citizens were without health insurance.

Unfortunately, while the number of uninsured Americans is on the rise, the ability of hospitals to absorb the cost of their care has waned. Recently-imposed Medicare reimbursement caps and increased competition among health care providers has severely limited the ability of hospitals to finance uncompensated care by shifting costs to public and private third party insurers. As a result, hospitals often deny uninsured individuals access to emergency room care, require large deposits before care is provided, or "dump" individuals from hospital to hospital until one finally agrees to provide "charity" care. I realize that hospitals do not engage in these practices voluntarily, and I hope our committee will consider policy alternatives which can help to alleviate this problem.

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age comes at an age when the risk of illness increases; a time when an accident or prolonged illness could become a crippling financial burden. I am therefore pleased that today's hearing will focus on these so-called "near elderly" citizens, and what their lack of coverage means for our growing population of older Americans.

In my view, there is much that can be done at the State and Federal levels to improve the access of uninsured Americans to adequate health care. My own State of Connecticut has established an assigned risk pool from which individuals can buy health insurance at reasonable and standard rates. While this system does not address the needs of the indigent uninsured, it does provide coverage for those who cannot obtain private insurance because of pre-existing medical conditions. Representative Barbara Kennelly has sponsored legislation in the House which would encourage other States to set up similar pools, and I understand that Senator Heinz will soon be introducing a companion measure in the Senate.

I hope our witnesses will feel free to comment on the merits of the "risk pool" concept as well as other States' efforts to provide coverage to individuals and reimbursement to health care providers. The dialogue we establish here today can go a long way toward helping policy makers at all levels to meet the needs of our "Americans at risk."

Chairman HEINZ. Unhappily, those are not unusual stories. I thank you for noting the legislation that I am introducing today, that there is a companion measure in the House. I emphasized earlier that it applied to just one small group of the uninsured, those who because of some pre-existing medical condition are turned down because they present a high financial risk to insurers.

Ms. Morrison has testified at some length as to a number of instances of that. I hope that we will get a full debate on whether our legislation is a good way to proceed. There are other ways to proceed, such as trying to amend ERISA. But I see no current interest in the Congress of opening up all the doors and windows of ERISA to the vagaries of the House and Senate at this point.

So, while there are features in my own legislation that might be in a sense second-best to attacking the problem through ERISA, that seems a long way off, and I think we had probably better try and do something rather than nothing. But that is not a judgment we have to make today.

I want to say, Ms. Morrison, I am going to put your entire statement, which you highlighted, in the record without objection.

I want to return, if I may, to Ms. DiLombard, just to flesh out parts of her story.

Ms. DiLombard, I understand that although your cancer was diagnosed in Arlington, TX, you had to go to Michigan to try and get treatment. Why did that happen?

Ms. DILOMBARD. Because I did not have insurance. When I had the biopsy done, I had to pay cash before I could have it done in day surgery in Arlington, and that was only for about a 3- or 4-hour stay. And that was when I had tubes put in my ears also, because I could not hear.

Chairman HEINZ. So the people in Arlington said, "Look, you don't have insurance; you've got to go someplace else"?

Ms. DILOMBARD. Well, that is just the way it is. And if I had gotten treatments in Arlington, I would have to pay at least half of it, something like $3,000 or more, and I did not have the money.

Chairman HEINZ. So, how did you happen to end up in Michigan?

Ms. DILOMBARD. Because Michigan is my home, and I thought I could get help here.

Chairman HEINZ. So you thought that you could be on Medicaid in Michigan, and get health care there?

Ms. DILOMBARD. Something, yes.

Chairman HEINZ. We talked about how you were rather stunned and surprised when you were turned down for Medicaid. Did you at any point ever have the opportunity to continue your health coverage when you worked for the cannery after you became unemployed?

Ms. DILOMBARD. No.

Chairman HEINZ. Was there any what they call a "continuation option" where if you paid more money, you could continue to have health insurance coverage?

Ms. DILOMBARD. You could for the first year, but the premiums were quite high when you were paying it yourself, and I just had a small budget that I had to live on.

Chairman HEINZ. Do you remember how much those premiums were?

Ms. DILOMBARD. About $150 or so a month.

Chairman HEINZ. One hundred and fifty dollars a month?

Ms. DILOMBARD. Yes. It is quite high.

Chairman HEINZ. So that is $1,800 a year.

Ms. DILOMBARD. That was through Mutual of Omaha, through the Fishermen's Union in Seattle.

Chairman HEINZ. How much income did you have coming in to you at that point?

Ms. DILOMBARD. In 1984, I had applied for Social Security. I saved just enough of my earnings just to get by, so I just could get by through the winter. And this was why I went to work in Alaska, because I could get just enough money to get by through the winter.

Chairman HEINZ. So that $150 would have been a big bite out of your available income.

Ms. DILOMBARD. Yes.

Chairman HEINZ. Did you say that it would only have been allowed to continue for 1 year?

Ms. DILOMBARD. Yes. You have to renew it every year.

Chairman HEINZ. So even if you could have afforded it, it afforded you only a limited period of coverage; is that correct?

Ms. DILOMBARD. Yes.

Chairman HEINZ. Let me return to Ms. Morrison at this point. Ms. Morrison, in your experience, are the stories and the experiences of Ms. DiLombard and Ms. Shuffler unusual?

Ms. MORRISON. No, they are not unusual, Senator, unfortunately.

Chairman HEINZ. You have seen a number of cases like that?

Ms. MORRISON. Yes, I have.

Chairman HEINZ. You testified to several that are similarly related.

Ms. MORRISON. Yes.

Chairman HEINZ. In other insurance fields, such as automobile insurance, there are drivers who are bad risks, and they can purchase insurance.

Ms. MORRISON. That is correct.

Chairman HEINZ. No matter how bad they are. They may have to pay a higher price.

Ms. MORRISON. If they want to pay for it, yes.

Chairman HEINZ. But in some cases here, in the health insurance market, if you have a pre-existing medical condition, you are almost lucky if you can pay for it at a higher price—you are lucky if you can get it at all.

Ms. MORRISON. That is correct.

Chairman HEINZ. It is sometimes just impossible for an individual to get any health insurance at all, regardless of price.

What is it about the health insurance industry that causes this problem?

Ms. MORRISON. Well, I think that is a broad question, and I am not sure I can answer the whole thing. But I do know, for instance, one of the things that concerns me the most is that when you are a driver, you have the option of being a terrible driver or being a good driver; that is a personal choice—if you are going to drive too fast, if you are going to have a car that is considered a sports car with a higher replacement value and so forth. Then, you have the option of driving slower or driving a safer car.

I do not believe that option exists for most people. They do not opt to have serious health problems.

The problem I am most concerned about right now, besides the conversion, is that the extension is only available currently in about 10 States, and the extension State by State is very mercurial. Some States will give you 90 days extension, some States will give you 1 year. The maximum, I believe, is 2 years. But very frequently, the problem is that the person who has the time to convert does so at the time of a death or a divorce or a separation, when other traumatic things are going on in his or her life, and this probably is not the highest of priorities. It gets put on the back burner, and the conversion day may even pass before they are aware of the deadline.

The other thing that concerns me a great deal is, as more companies move to self-insuring, they are taking themselves out of the guidelines and the rules that exist to allow for continuation of coverage. And I think we have seen a case of that this morning. And there are going to be more and more companies moving to self-insurance as the health costs continue to rise and they are trying to put a cap on them.

Chairman HEINZ. But it is clear that death of a spouse can leave women in particular totally unprotected. What can we do at the Federal level? You mentioned how the people at the State level say it is a Federal problem, the people at the Federal level say it is a State problem. But what can we do at the Federal level, assuming that the first group of people are right, to help?

Ms. MORRISON. I would like to see Federal legislation, frankly, because I think that there are two important points on it. States have their own feelings about whether this is a priority issue or not, so you end up moving from State to State, and I think that is unfortunate at best; it should not be required. But on top of that, because this is a national problem, I would like to see something that clarifies it from the point of view of the insurance companies, because the insurance companies hate legislation that goes State by State. They say this makes it change their risk categories. And in Maryland, because Maryland is quite strict for insurance, there are many companies that cannot write in Maryland at the

moment. If you want to use that particular package, you must go to Pennsylvania or Virginia.

So from an insurance company point of view, it is, frankly, much easier for them to have one law that they must adhere to, and then they can tune their product across the board, and they do not have to have minor fine tuning for coverage in one State as opposed to another.

Chairman HEINZ. I may have one other question for you, but first I want to recognize two other colleagues who have joined us—Senator Glenn, the ranking member on our committee, and Senator Chiles, who used to be the chairman of this committee.

Senator Glenn, do you have an opening statement or any remarks?

Senator GLENN. Mr. Chairman, I do have an opening statement. I apologize for being late. I had another committee meeting this morning that just ended, and I was delayed over there.

STATEMENT OF SENATOR JOHN GLENN

Senator GLENN. As ranking Democratic member of the Senate Special Committee on Aging, I am pleased the committee is holding today's hearing entitled "Americans at Risk: The Case of the Medically Uninsured." Given public and private medical cost containment initiatives in recent years, we all know that the health care industry is in a state of change. We do not know what the marketplace will look like 10 or even 5 years from now. However, we do know that to have a healthy nation, we must have healthy people—this goal requires adequate access to necessary medical care.

During the past 30 years, health insurance has become widely available and affordable for most Americans. We have made its financing a responsibility of both the public and private sectors in order to expand access. As health insurance protection has grown, advances in medical technology that have improved the quality and delivery of health care, have become a source of national pride. Without question, these accomplishments merit praise.

In the past few years, however, we have seen a sharp break in the steady postwar growth of health insurance coverage in this country. Between 1979 and 1982, the number of uninsured Americans increased by a third. Today, it is estimated that as many as 35 million people are uninsured. However, if we look to the question of adequate coverage, insurance gaps are much greater. Although estimates vary depending upon definition, intermediate projections are that at least 13 percent of insured Americans are in danger of financial ruin should a major illness strike.

Who are these people? The prospects of being without health benefits or adequate insurance correlate with factors of age, sex, and income. Uninsured medical expenditures for women and their dependents are almost double those for men. Lack of coverage also represents an important gap in protection for Americans approaching age 65—people who are more likely to have expensive medical bills. Again—as with other aging-related issues—this represents a special problem for women. Widows and divorced women, between the ages of 55 and 64, face a 1 in 5 chance of being uninsured.

Rising health care costs are a major reason for the increasing number of uninsured Americans. In recent years, as a solution to medical cost inflation both the private and public sectors have been cutting coverage. During the 1982 recession, employers began cutting benefits, particularly those going to spouses and dependent children. Similarly, Medicaid funding has been cut dramatically and the program now serves less than half of all Americans living below poverty. As recently as 10 years ago, Medicaid insured almost two-thirds of those living in poverty. Moreover, since 1981, the budgets of other categorical health care programs have also been slashed.

As the pressures have mounted for hospitals to finance more charity care and bad debt, institutional ability to absorb the costs of this kind of uncompensated care appears to be dwindling in the new era of medical cost containment and, relatedly, increased competition. More and more the financing of indigent health care appears to be falling disproportionately on some types of providers and some communities. Public hospitals, inner city hospitals, and other institutions appear most burdened by uninsured admissions. Perhaps most importantly, access to needed care does not appear to be keeping pace with the increased number of uninsured Americans.

These circumstances merit our immediate attention. During recent Senate consideration of the fiscal year 1986 budget resolution, I opposed further cuts in Federal Medicaid funding and sought to add back revenue to help pay for the costs of uncompensated care under the Medicare Program. Unfortunately, while many of my colleagues joined me in opposing further spending cuts, these amendments were defeated. Therefore, I hope that this hearing will shed light on what our Federal budget priorities need to be with regard to helping the States, local hospitals and communities finance uncompensated care.

This hearing raises questions concerning Medicare reimbursement to hospitals that treat disproportionately large numbers of low-income patients. Numerous studies have shown that hospital care for indigent patients is more costly than equivalent care for other patients. Low-income patients have less access to preventive care and are more severely ill than the average patient when they enter the hospital. The Congress has instructed the Department of Health and Human Service [HHS] to make appropriate adjustments in Medicare payments rates for hospitals serving disproportionate numbers of low-income beneficiaries. Yet, HHS has ignored this mandate. With regard to this specific issue, I am disappointed that we do not have an administration witness testifying before the committee today.

Finally, this hearing raises another major policy question regarding Medicare. President Reagan's Social Security Advisory Council has proposed delaying the age for Medicare eligibility by 2 years, to age 67. According to the Health Insurance Association of America, enactment of this proposal would add 2 million elderly Americans annually to the ranks of the medically uninsured. President Reagan's fiscal year 1986 budget included a proposal to delay, by 1 month, the Medicare eligibility age in order to reduce Federal outlays. According to studies, as many as one-half of early retirees

today do not have health insurance coverage continued by their employers. At a time when employers are curtailing employee and retiree coverage, we need to question who will take care of these people.

I look forward to hearing today's testimony. I am especially pleased that we have Henry Manning, president of the Cuyahoga County hospital system, in from Cleveland, OH, to testify before the committee this morning. We are, without a doubt, a compassionate nation. I believe we must continue our commitment to help protect all Americans from the financial burden of illness.

Chairman HEINZ. Let me just recognize Senator Chiles, if he has any comments he would like to make at this point.

Senator CHILES. Mr. Chairman, I have an opening statement. I think I can reserve it for the record. I am anxious to hear Senator Dodd.

Chairman HEINZ. Without objection, so ordered.

[The statements of Senators Chiles and Denton follow:]

PREPARED STATEMENT OF SENATOR LAWTON CHILES

There are 35 million Americans today with no health insurance. Some simply choose to take the risk themselves, assuming they can pay for medical care if needed. But many cannot pay large medical bills and don't have any insurance either because they cannot afford to buy it, or because no one will insure them.

We will be hearing testimony today from individuals who have found themselves in the nightmare situation of being ill, needing medical care, and having no way to pay for it.

And as I think we will hear, you don't have to be destitute to be in this situation. With medical costs as high as they are, even a short-term hospital stay can cost enough to wipe out a life's savings—or preclude treatment at all unless someone is willing to step in and provide care without charge.

That nightmare situation for a patient is one side of the coin. On the other side are the hospitals and other health care providers who find themselves being asked to provide more and more free care to the uninsured poor.

For those who need help who are lucky enough to live near a hospital willing to provide that care, it is a blessing. For the hospital, it is becoming a growing financial burden. And, unfortunately, there are some indications that hospitals who have historically assumed more than their fair share of this burden may be forced to provide less and less—or, at worst, to close their doors. That is something that none of us want to see happen.

That is why I tried earlier this year to see that the Medicare reductions in the Senate budget resolution were at a level sufficient to allow some adjustments within the current hospital reimbursement formula to recognize this problem for some hospitals. Unfortunately, I don't think that the budget resolution finally passed by the Senate makes an adequate allowance for recognizing this "disproportionate share" burden.

That alone is clearly not sufficient to address the whole problem of those without insurance who cannot pay for medical care: During the two-year period 1980 to 1982, the proportion of the Nation's poor without health insurance coverage rose by 20 percent—while the amount of free care provided by the Nation's hospitals only grew by 4 percent. But we certainly don't want to deliberately make the situation even worse.

There has been some action at the State level to address this problem. I am proud that Florida has been a leader, recently enacting legislation to create a special trust fund for medical assistance for those who cannot pay.

What is most interesting about the Florida action is that the trust fund is basically funded by an assessment on all hospitals in the State. In essence, those hospitals which do not serve the poor help pay for the care received at hospitals which traditionally have provided more than their share of free care.

I know that we will hear several other approaches to solving this problem, and I look forward to hearing from our witnesses.

PREPARED STATEMENT OF SENATOR JEREMIAH DENTON

Mr. Chairman, during the last 2 weeks the Special Committee, under your leadership, has held two very important hearings on the subject of "risk." "Risk" is often defined as the "hazard or chance of loss." Last week's hearing illustrated that millions of Americans are hazarding the chance of loss of their retirement income because of the inadequacies of the pension system. Today's hearing illustrates that millions of Americans of all ages are hazarding the chance of receiving inadequate medical care because they are medically uninsured. As the staff report indicates, for a variety of reasons as many as 35 million Americans find themselves without health insurance. It is perhaps a cliche, but certainly true, to say that that situation represents a serious national problem.

Each of us has read or heard of instances in which uninsured people are denied admission to hospitals because they cannot pay for services. Those patients often end up in financially overburdened public hospitals and teaching hospitals. The trend is disturbing, since care delayed may be equivalent to care denied. Perhaps just as disturbing is the possibility that, for fear of crushing debt or out of simple embarrassment, many of the uninsured are simply not seeking needed medical treatment.

Although the scope of the problem may be easy to assess, I am afraid that comprehensive and easy solutions may not exist. As always, practical solutions will have to be found through the combined efforts of the Federal, State, and local governments. Moreover, private insurers, hospitals, and physicians must be involved in any real effort to help the medically uninsured.

I wish to assure the Chairman of the Committee that I intend to follow the issue with care, and that I appreciate his efforts to highlight through hearings like this one, the unmet needs of many older Americans.

Chairman HEINZ. Senator Dodd?

Senator DODD. Very briefly, Mr. Chairman, the thing that strikes me, I suppose, not only just about this particular kind of a case that we are dealing with here this morning, but so many others that are related, is the lack of attention to the preventive care side of this issue; that if we could focus more on that—we can talk about legislation and so forth—but in that preventive care arena, I would suspect that a significant percentage of that 1.5 million people who are in that 55 to 64 age category who are uninsured today, are likely to end up with a medical problem that requires treatment and hence, tremendous cost associated with it. I think it is one in five, or one in six, of widowed or divorced women who are likely to be uninsured who are in that same kind of category.

I would like the panel to just comment on that. You have all had a variety of experiences to deal with it, but I would be curious whether or not you agree with the notion that somehow, preventive care could play a significant role in the reduction of this particular problem, and second, what you might suggest we incorporate in terms of our suggestions with regard to preventive care programs.

Let's start with you, Ms. Morrison.

Ms. MORRISON. Thank you.

Obviously, preventive care is extremely important, and I think philosophically, more of your medical carriers are moving to that with the HMO's now offered as an option. Specifically in this area as to Blue Cross/Blue Shield, we have changed from a philosophy of, "After it is broken, come in, and we will talk to you about fixing it," to having an annual checkup and so forth.

But I can tell you from my own personal experience in the last 2 months that preventive care is not exclusively the answer. And I can speak specifically to my mother who in April had a complete checkup, was pronounced to be in the best of health, and went to

the Everglades with the Smithsonian on a walking tour kind of situation, came back in May, had a little stomach problem and has now been in the hospital for 5 weeks with pancreatic cancer.

There was no indication, no warning. She has had major surgery, and she starts radiation on Monday.

Senator DODD. Well, I did not mean to suggest it was the answer.

Ms. MORRISON. I know.

Senator DODD I know there are cases like that.

Ms. Shuffler.

Ms. SHUFFLER. Well, in my case specifically with the cancer, that would not have been the answer, except that had I had other illnesses—I did not go for regular checkups because I could not afford the price of a doctor's visit.

Senator DODD. Yes. They avoid doing that.

Ms. SHUFFLER. Yes.

Senator DODD. Ms. DiLombard.

Ms. DILOMBARD. Well, that's about the same thing here. I had gone to the doctor earlier in the fall when I was having a lot of sinus problems, I thought, and he did not think it was anything, just sinus infection. So when I got to Arlington in December, I got worse, and I decided I had better look into it, and that is when they discovered it was cancer.

Senator DODD. Well, I thank you for coming here today, both of you, and of course you, Ms. Morrison, as well, for your testimony this morning.

Mr. Chairman, I have no further questions.

Chairman HEINZ. Senator Glenn.

Senator GLENN. I would just like to follow up a little bit, and if this has been covered earlier, why tell me Mr. Chairman, because I do not want to repeat questions you may have already gotten into or comments you may already have made here. One of the difficulties in looking at this as a national problem is we are seeing an increase in the uninsured. For many years, through our policies here—and we can all argue whether they were right or wrong, and on social programs, and so on—I think they were right, by and large, that is not to say every program works perfectly—we have encouraged health insurance expansion. I think our concern to see that every single American has adequate health care at whatever age was good. And maybe we did not have enough money to do everything for everybody, but we were moving in a general direction that most people in the country accepted.

Now, we are finding over the last 4 or 5 years a decrease in the insured, and that is a very difficult situation for me, and it is very difficult for me to accept. I know we all have our own personal horror stories about this. My dad was a plumber, with a very modest amount saved for retirement—owned a home and so on. About 2 years after dad and mother retired, he came down with cancer, and it was a downhill slide. And he did not lack for medical care, because I could pick it up, but all their savings went in the first couple of years—everything. And if they had not had other family members around to pick that up—as too many people don't have—then, what happens?

And I just refuse to throw people like that on the ash heap of history and say, "That's just tough. You should have provided more

for yourself early." Medical costs have gone up, and you could not have foreseen that. How could you see the cost of medicine going up? Part of it has been because we have increased how good our medicine is. So there are a lot more things available now than any of us ever thought were going to be possibly earlier on. But how do we make sure that every American has a shot at getting that kind of good medical care? That is the problem. That is what we are up against here. And we see the huge budget cuts and wanting to regress, as I see it, in these areas, instead of making sure we at least hold where we were, and hopefully, expand coverage to more people in the country and make it better—instead seeing fewer people insured and fewer people having a good chance for good medical care. And that is what this committee has to grapple with.

I just wanted to make that as a sort of short summary of my more lengthy statement.

I have favored catastrophic health insurance for many years—I think the move to a whole national health insurance plan would cost, I do not know what the current estimates are, $200 to $300 billion, I suppose, something like that it is now. But I do favor, and have ever since I have been in the Senate, catastrophic insurance so that people like yourselves do not get wiped out. You come up against something that is beyond your capability, and you are going to wind up—I think in your testimony one of you said, as I was reading here a moment ago, you are going to lose your house, your home. What are you going to do? Where are you going to live? What are your resources? Certainly, that is something we all share together as a danger, and we can share that together, it seems to me, as Americans, because very few people will not be wiped out by some medical catastrophe if it happened to hit them. So that is what we have to deal with here.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Glenn, I think that is very well said.

Senator Chiles.

Senator CHILES. Mr. Chairman, I associate myself with Senator Glenn's concerns, and all of our concerns, and my State happens to be one, Florida, that is particularly hard hit because we have so many elderly moving into the State, and by virtue of that move, so many of them lose their coverage, and then have a terrible time trying to get reinstated or trying to pick up some additional coverage.

I know one of the things we are grasping and groping for is how do we find an answer for this. There has been some action at the State level to try to address this problem, and I am proud that Florida has been a leader in recently enacting legislation to create a special trust fund for medical assistance for those who cannot pay. What is most interesting about the Florida action is that the trust fund is basically funded by an assessment on all hospitals in the State, in essence, those hospitals which do not serve the poor, and we have seen this tremendous increase in the for-profit hospitals, many of which elect what services they are going to make. And in many instances in my State, they were coming in and they were buying the existing municipally owned hospitals, or some of the nonprofit hospitals, or substituting themselves in place, and then they were taking a proposition where, "We don't take certain

cases, and we don't do this and we don't do that." Well, the State Legislature in Florida has finally said, regardless of what you do or do not do, there will be an assessment on you, and that assessment, for those who do not traditionally serve the poor as being a municipally or county owned hospital help pay for the care received at hospitals which traditionally have provided more of that service. What we found is, again, when one of the for-profit hospitals comes in, that puts a tremendous additional burden on wherever the municipal hospital was, because they had to pick up the services.

So, the State is trying to speak to that. I do not say this is the whole answer; I do not think it is. But there is this assessment, and it is helping provide some way of taking care of people that do not have this coverage now.

Chairman HEINZ. Senator Chiles, thank you very much.

I have one last question for Ms. DiLombard, which is this. You testified that you could not afford the kind of insurance that was available in your continuation policy.

Ms. DILOMBARD. Yes.

Chairman HEINZ. If you had been able to obtain it at the same price, the same cost as your husband had it before, would it have been affordable? Was it a fully employer-paid plan, or did he contribute directly to it?

Ms. DILOMBARD. It was full insurance. He had died about 27 years ago, so I raised my children by myself. They were very little when he passed away of a heart attack. And I could not continue the premium at that time, because we did not have—well, we did have some insurance that paid for a lot of the stuff, and then we got Social Security for the children, and I had a widow's veterans pension, a little bit of that. But that was taken away after I started working.

Chairman HEINZ. Now, Ms. Morrison has indicated to us that she thinks there ought to be Federal legislation to help solve this kind of problem. Would you agree with that?

Ms. DILOMBARD. Yes, I do.

Chairman HEINZ. Ms. Shuffler, would you agree?

Ms. SHUFFLER. I certainly would, sir.

Chairman HEINZ. I guess, in view of your experiences, I am not surprised. But obviously, there are a number of us who feel the same way here. I thank you for helping to build a very strong case for our not only listening and learning of the problems, but moving ahead to try and do something about them.

Senator Glenn.

Senator GLENN. Yes, just one last question here.

Ms. Morrison, with regard to ERISA, would you recommend changing the act to address the health insurance conversion issue for spouses, and what about changes to Medicaid along with it?

Ms. MORRISON. Well, what I would like to see is some way that the employers cannot eliminate their responsibility when they move to a self-insured program. Until a couple years ago—and I would like to just move back very briefly and touch on your earlier remarks—because until a very few years ago, there were a number of very small insurers that created trusts out of individual coverage. So, assuming someone did not have a history of problem that precluded them looking for coverage, it was possible to get insur-

ance for individuals by grouping them together and creating an association.

What happened a couple of years ago is when we went into our recession, people used much more of their optional coverage prior to losing it or being laid off, and for those people who continued to work, we began to see stress-related diseases. These insurance carriers suddenly found themselves with high deficits. There were tremendous losses, and they had to close up these associations.

Now, as we see more companies moving to self-insurance, it is compounding the problem. So I think what we have got to do is share the risk, pool the risk. And I am not a lawmaker—I leave that to you all—but what I see are the people who, as a result of the lack of the law, come to me and fall through the cracks.

Senator GLENN. If I read you correctly, you would say that we cannot just say that you are going to change that and make a conversion automatic, without figuring out how we are going to fund it, because the people who would be funding the conversion are not solvent.

Ms. MORRISON. That is right. Your conversion is all right, but it is only one very small part of the problem. The conversion that is automatic under the Blues allows you to continue your coverage. However, you are going to now pay twice as much for half the benefits. The conversion right to remain on the policy and pay both your part and your employer's part, at least, with the few States that have it, gives you a short period, usually about 1 year, perhaps in one or two States, 2 years. For the widow or the person who is older and who is not going to be employed, this is at best a stopgap measure; it does not solve the problem.

Senator GLENN. Well, I think we will get into some of the problems of Medicaid and so on a little bit in the next panel, I believe, so I will save some questions there. But do you suggest any changes in Medicaid?

Ms. MORRISON. I am really not sure how it needs to be solved. I will leave that to the second panel. What I want is, as I mentioned earlier, a more fair distribution of risk, because it is too easy to shift the burden, to say, "Well, I no longer am responsible for this group," whether we move it to the Medicaid group. And we are not talking about an indigent group of people exclusively; we are talking about many people who could afford the coverage if they had access to it. So, under Medicaid, technically, they would not be eligible. They still would be excluded.

Senator GLENN. That's one of the things I have objected to very strongly—and I am not against shuffling some of the responsibilities of the Federal Government back to the local level, which is a giant movement that the administration has initiated, of course. And I think in some areas, that is appropriate. But I think to just assume that in this medical area, given the tremendous expenses involved with it, that we can do that in a very short period of time, is wrong. It involves hospitals, tax rates, bonding, and a whole bunch of things, that take years and years for communities to set up, even if they are capable of doing it—which not all of them are—but, even if they are capable of doing it. You cannot pass a law in Washington, DC, in June of this year that is going to take effect in October, or cut funding that is going to take effect in Octo-

ber, and say to Cleveland or Pittsburgh, or wherever around the country, "OK, pick it up. We know we have been in this for years, and you have been depending on this thing, but now, you guys just pick it up locally, and everything will work out all right, because it is now going to be locally controlled." It is just flat nonsense, and I just disagree with that way of budgeting completely, especially on these programs that get right to the heart of whether people live or die. And that is what we are up against.

That is a statement more than a question, but it is something that affects us all.

Ms. MORRISON. If we go State by State, you are going to see intensive lobbying by each of the insurance industries as we have in other things.

Senator GLENN. And whether you are going to get even reasonable health care—not good, but any health care—is going to depend upon more a factor of where you happen to live. What State and community you are in, and are you in a declining economy there in that community or not—and that is what is going to determine whether you live or die, maybe.

Ms. MORRISON. Exactly. Unfortunately, you are correct.

Senator GLENN. Yes. Thank you, Mr. Chairman.

Chairman HEINZ. Ms. Shuffler.

Ms. SHUFFLER. I want to mention one more thing, which may or may not be relevant. It has been assumed that once you go on Medicare, everything is better. Well, it is better, but the one thing that Medicare does not take care of—for instance, talking about preventive medicine, I am on oral chemotherapy, and this is controlling my illness. But I take pills that cost $1 apiece, and I take four a day so far.

Chairman HEINZ. And there is no coverage of prescription drugs like that under Medicare.

Ms. SHUFFLER. No coverage under Medicare for that.

Chairman HEINZ. That is a major, major costly hole in the Medicare Program. It is very expensive.

Ms. SHUFFLER. Yes.

Chairman HEINZ. It really relates to the fact that Medicare does not have any protection for what we call long-term care. A lot of people think it does. While I think you could correctly define medication to control an illness such as you are taking as preventive health care, Medicare, in a sense, has let its philosophy—if there ever was one—of not paying for long-term care control its decisions on whether or not that kind of medication should be paid for, because one way of looking at it is you are going to take that for a long time, and that becomes long-term care.

We have no long-term care policy in this country. We have no very definable preventive health care policy in this country. We have no real health maintenance orientation, except here and there, depending on, I suppose, health maintenance organizations being an exception in this country.

You have, I think, put your finger on something that we should continue to struggle with and work to achieve a solution.

Ms. SHUFFLER. Thank you, Senator.

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Chairman HEINZ. I want to thank all three of you. You have come long distances, and you have made a very valuable contribution to our record. I thank you all.

Ms. MORRISON. Thank you, Mr. Chairman.

Ms. SHUFFLER. Thank you.

Ms. DILOMBARD. Thank you, Senator.

Chairman HEINZ. Our next panel is Dr. Gordon Schiff, Henry Manning, Dr. Uwe Reinhardt—no stranger to this committee—and Patricia Butler.

Gentlemen, and Ms. Butler, would you please come forward?

I would like to ask Dr. Gordon Schiff, of Cook County Hospital, to be our first witness on the panel. Dr. Schiff, welcome. Thank you very much. Please proceed.

STATEMENT OF DR. GORDON SCHIFF, M.D., CHICAGO, IL, ATTENDING PHYSICIAN, COOK COUNTY HOSPITAL

Dr. SCHIFF. Thank you.

I am Dr. Gordon Schiff. I am actually not an expert on health policy. What I am becoming an expert on, unfortunately, is some of the side effects of policies that are occurring.

Specifically, I would like to talk about two things. One is the growing "dumping" problem that we are observing and documenting in Chicago, and also to describe what I believe is for the first time, a brand new mode of health care delivery which is what I call the hype-ER-acute admission to the hospital.

For the past 3 years, 500 patients per month have been transferred directly from the emergency rooms of private hospitals to Cook County Hospital in Chicago. These acutely ill patients are patients whose medical condition is judged by the referring physician to be sufficiently serious as to require immediate hospitalization, yet are refused admission to these private institutions primarily for economic reasons.

Often, they are so sick that they must remain in the private hospital emergency room for 12 to 16 hours before they are stable enough for transfer. The number of such transfers has increased 500 percent since 1979.

This practice is often referred to as inpatient "dumping". However, these direct, emergency room-to-emergency room transfers represent only the tip of the iceberg, and constitute but a fraction of the overall dumping problem that we are seeing.

Outpatient dumping is a phenomenon whereby patients, previously served in the private sector or in community clinics, are being shifted onto the public hospital. This is occurring on a much larger scale. Because these direct, ambulatory transfers are much less visible, and more difficult to define, there exists little data on this problem. We therefore chose to do a study to estimate the magnitude of this problem.

We surveyed 500 patients waiting to be seen in our adult emergency room during November of 1984. Our study disclosed that outpatient dumping is occurring on a massive scale. Even using the narrowest definitions of "outpatient dump," which we will look at in a second, we project that 25,000 patients are coming by foot to Cook County Hospital per year, being turned away by private and

community sources of care. In addition, another 50,000 patient visits are resulting from patients coming to Cook County Hospital because they can no longer afford the care they were previously receiving elsewhere.

The problem we studied is illustrated by "Mr. D.B." He first presented to a private hospital emergency room with new onset of jaundice, seizures, and was found to have bleeding in his urine and his stools. This is a patient whom I cared for at county hospital. Examining the case, this man should have been admitted at once to the other hospital. Instead, he was discharged from their emergency room with the papers that I have a copy of, that instructed him to go to Cook County Hospital at once.

Such patients, transferred indirectly "by foot" do not get included in the usual transfer statistics. Other patients may have a less urgent need for followup care, but are being referred to Cook County Hospital for additional care and additional tests, for problems that have been identified in private hospitals or clinics.

Figure 1 [1] shows the six categories of dumping and the numbers of patients who fell into each group for our study. If we extrapolate from this small sample of 500 patients to the 200,000 emergency room visits annually at our institution, we get a rough estimate of the magnitude of the dumping.

Let me just call your attention for those of you looking at the figure, to what we defined as categories A, B, C, primarily the A and C. The group of patients in category A were patients who were refused care somewhere else—they went to another hospital or emergency room, sought care, and they were refused, and generally, they were told to go to county, and this was for economic reasons—that constituted 4.6 percent, or 5 percent, of the sampie we surveyed. A smaller group went there and left without being seen. Mainly, they saw a sign on the wall that said you need $50 or $75 up-front, and they came to county because they could not afford it. Another group, C, were explicitly told to go to Cook County Hospital by their previous source of care. They were patients who were being cared for somewhere else; something was discovered—somebody discovered an abdominal mass on a patient, and they said, "You are going to need tests, ultrasound, x rays, and since you don't have any money or insurance, you had better go to the county." That was sort of a generic problem with that group of people. There were 35 such people, or 7 percent of our sample that fell into there.

And again, the last column translates that group of people into the total number of patient visits that that would represent. In that case, the first three groups is 25,000 people a year. That is our conservative estimate of the number of patient visits that we are seeing from what I would call the more blatant or explicit forms of dumping.

The other categories are delineated below, and we can discuss those if there is time and interest.

As distinguished from inpatient dumping, where virtually every patient referred is accounted for, unless they expire in the ambu-

[1] See p. 34.

lance en route, counting outpatients who arrive at Cook County Hospital significantly underestimates the number of patients who are referred. We have no way of knowing what fraction of the patients told to go to county actually comply with this and come. These "lost" patients, unable or unwilling to come to Cook County Hospital, are in some respects of even greater concern than the huge numbers that are actually arriving.

Another concern is the cumulative impact of this shift. Many of those seen in the emergency room require followup care, which we have been unable to provide. During the past 2 years, 400 patients per week are referred to the general medical clinic, which is where I work. The clinic takes in only 120 new patients per week. No one knows what happens to those remainder who are unable to be given appointments.

During the past 15 years, hundreds of millions of public dollars have gone toward the purchase of the lastest equipment and new wings for the private hospitals in Chicago. It is ironic that Medicaid patients are now finding themselves excluded from the very facilities that Medicaid dollars helped to build. Meanwhile, Cook County Hospital, where they are sent, is an outdated structure, and it is operating with no additional resources to handle these "unprofitable" patients.

I have included a figure which is a year old, but it gives you a sense of the failure of the Cook County Hospital budget to keep up with the overall rate of increase in medical inflation, given a constant number of patients.

In conclusion, we are witnessing a growing number of emergency room-to-emergency room transfers. However, for every one such ambulance referral, we estimate that there are at least 5 or 10 ambulatory referrals plus an unknown number of patients never making it to the emergency room of our institution.

The life-threateningly ill "ambulance" patients have been and will continue to make the headlines and be the subject of malpractice suits. These everyone has seen—I would refer you to the February 6 issue of the New England Journal of Medicine for an editorial and a lawsuit finding that refers to this problem. The lengths to which the private hospitals are going to avoid admitting patients—because once a patient is admitted to the hospital, they cannot transfer him or her—is extraordinary. We have seen practices such as giving dopamine for shock, which should only be done in an intensive care unit, not an emergency room; 10 to 20 units of blood, again in the emergency room; spinal taps and treating meningitis in the emergency room—all to avoid admitting the patients. This is to get them stable enough to transfer them.

I would label this new form of health care delivery the "hype-ER-acute admission." It takes its place along with acute care hospitalization and freestanding emergency rooms as a form of health care delivery, and I think, although it is certainly small in comparison, it is really a caricature of what is wrong with our health care system. The patient would be treated for this short period of time, in reality, risking the patient's life by not admitting him to the hospital, in order that he may be transferred to another facility.

The magnitude of this larger, though less dramatic, problem of outpatient dumping is affecting many more people, and its ramifications, I contend, are no less devastating.

Chairman HEINZ. Dr. Schiff, thank you very much.

[The prepared statement of Dr. Schiff follows:]

PREPARED STATEMENT OF DR. GORDON SCHIFF

For the past three years more than five hundred patients per month have been transferred directly from Emergency Rooms of Private Hospitals to Cook County Hospital (C.C.H.) in Chicago. These are acutely ill patients whose medical condition is judged by the referring physicians to be sufficiently serious as to require immediate hospitalization, yet are refused admission at these private institutions, primarily for economic reasons. Often they are so sick that they must remain in the private hospitals ER for 12–16 hours before they are stable enough for transfer. The number of such transfers has increased 500 percent since 1979.

This practice is often referred to as inpatient "dumping." However these direct, Emergency room-to-Emergency room transfers represent only the tip of the iceberg, and constitute but a fraction of the overall dumping problem.

"Outpatient dumping" a phenomenon whereby care for patients previously being served in the private sector (or in community clinics) is being shifted onto the public hospital, is occurring on a much larger scale. Because these indirect, ambulatory transfers are much less visible, and more difficult to define, there exists little data on this problem.

To estimate its magnitude we surveyed 500 patients waiting to be seen in the Adult Emergency Room at C.C.H. during November 1984. Our study disclosed that "outpatient dumping" is occurring on a massive scale. Even using the narrowest definitions of an outpatient "dump" we project that 25,000 patients are coming by foot to C.C.H., being turned away by private and community sources of care. In addition, another 50,000 patient visits are resulting from people coming to C.C.H. because they can no longer afford the care they were previously receiving elsewhere.

The problem we studied is illustrated by Mr. DB. He first presented to a private hospital Emergency Room with new onset of jaundice, seizures and was found to have bleeding in his urine and stools. This man should have been admitted at once to the hospital. Instead, he was discharged from their E.R. with the papers I am holding which instructed him to go to C.C.H. Such patients, transferred indirectly "by foot" do not get included in the usual transfer statistics. Other patients may have a less urgent need for follow-up care, but are referred to C.C.H. for additional tests and treatment for problems identified by the private hospitals or clinics.

Figure 1 shows the six categories of dumping we defined and the numbers of patients who fell into each group. Extrapolating from this small sample of 500 patients to the 200,000 annual patient E.R. visits, we get a rough estimate of the magnitude of the dumping.

Figure 1

Definitions and Rates of Outpatient Dumping

Dumping Category	Definition (why are you here now)	Numbers of Patients	% of 500 Pts. Surveyed	# of pts translates to per year
A	*Refused Care Elsewhere* (& usually told to go to C.C.H.)	23	4.6	9,570
B	Sought Care Elsewhere but *Left Without Being Seen* (for financial reasons)	3	0.6	1,250
C	Explicitly *Told to Go to C.C.H.* by previous source of Care	35	7.0	14,560
D	Coming to C.C.H. now because *Can No Longer Afford Previous Source of Care*	78	15.6	32,450
E	*Dissatisfied* with Care Elsewhere *and Unable to Afford it* any longer	38	7.6	15,810
F	*Dissatisfied* with Care Elsewhere for *Other Reasons*	8	1.6	3,330
	TOTALS	185	37.0	76,960

Health/PAC Bulletin

As distinguished from "inpatient dumping" data where virtually every patient referred is accounted for (unless they expire in the ambulance enroute), counting outpatients who arrive here significantly underestimates the numbers of patients referred. We have no way of knowing what fraction of the patients told to go to C.C.H. actually comply. These "lost" patients, unable or unwilling to come to C.C.H., are, in some respects, of even greater concern than the huge numbers who are actually arriving.

Another concern is the cummulative impact of this shift. Many of those seen in the Emergency Room require follow-up care which we have been unable to provide. During the past 2 years 400 patients per week were referred to the General Medical Clinic where I work. The Clinic takes in only 120 new patients per week. No one knows what has happened to the remainder who could not be given an appointment.

During the past fifteen years, hundreds of millions of public dollars have gone towards the purchase of the latest equipment and new wings for the private Hospitals in Chicago. It is ironic that Medicaid patients are now finding themselves excluded from the very facilities that Medicaid dollars helped to build. Meanwhile, Cook County Hospital, where they are sent, is an outdated structure operating with no additional resources (Fig 2) to handle these "unprofitable" patients.

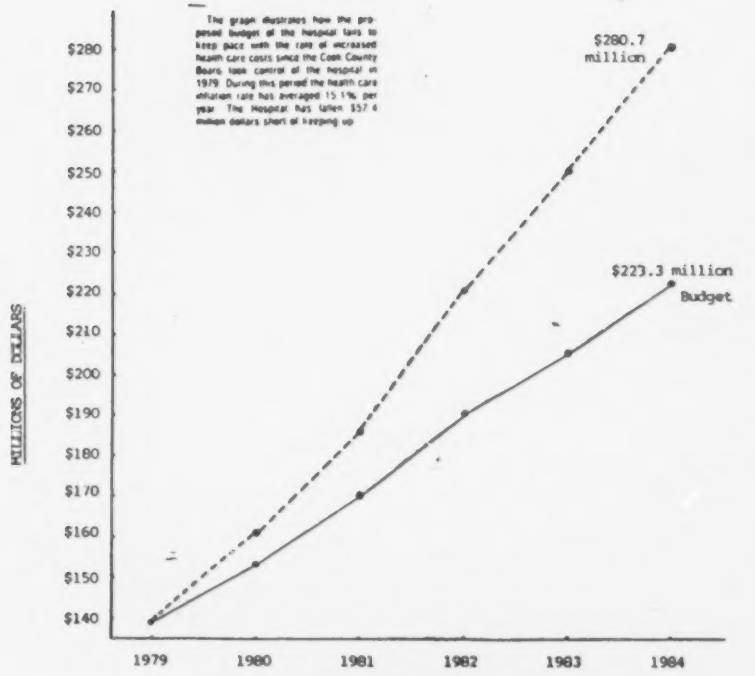
In conclusion, we are witnessing growing numbers of emergency room to emergency room transfers. However, for every one such ambulance referral we estimate there are at least 5 or 10 ambulatory referrals plus an unknown number of people never making it to our the emergency room of our institution.

The life threateningly ill "ambulance" patients have been and will continue to make the headlines and be the subjects of malpractice suits. The lengths to which private hospitals are going to avoid admitting them is extraordinary. Giving dopamine for shock, 10–20 units of blood and spinal taps and treatment of meningitis in the E.R. to "stabilize" them for transfer constitutes a brand new form of health care delivery which I call the "Hype-ER-acute admission." The magnitude of the larger though less dramatic problem of outpatient dumping is affecting many more people and its ramifications are no less devastating.

FIGURE 2

CHART SHOWING FAILURE OF COOK COUNTY HOSPITAL'S BUDGET TO KEEP UP WITH INFLATION (assuming constant # of pts)

APPENDIX ONE



COOK COUNTY HOSPITAL BUDGET IN MILLIONS OF DOLLARS

-Straight line indicates actual budget

-Dotted line indicates what the budget should have been if the budget had kept pace with the rate of health care inflation

Sources: Health Care Financing Review September 1982 and 1984 proposed CCH budget

Chairman HEINZ. I am going to yield to Senator Glenn to introduce our next panelist.

Senator GLENN. Thank you very much, Mr. Chairman.

I am very happy to introduce Mr. Manning—Henry Manning—who has been head of the Cuyahoga County Hospital System for many years. I believe you have been in that job about 15 years, so you have seen the problems from a number of different vantage points, and we are particularly glad to have your testimony here today.

I think Cleveland represents sort of what the problem is in many parts of this country. We have had a declining industrial base. We are coming back. It is a city that has been through the doldrums and has really been unable to take care of some of these problems on its own. Now, as a resurgent community to some extent—which we hope continues, of course—are all the problems of medical care, an increasing number of indigent people in our community there. You have had to cope with that throughout that whole Cuyahoga County Hospital System, and all the difficulties, across some 30-some municipal jurisdictions in Greater Cleveland and in Cuyahoga County. I think the advice you can give us in some of these areas is particularly valuable, because you have seen it all in your 15 years there.

So we welcome you to the committee today, Mr. Manning, and look forward to your testimony. Thank you.

STATEMENT OF HENRY E. MANNING, CLEVELAND, OH, PRESIDENT, CUYAHOGA COUNTY HOSPITAL SYSTEM

Mr. MANNING. Thank you very much, Senator Glenn.

I am particularly happy to appear before a committee on which you sit. Senator Glenn is a very good friend of our hospital, and intimately acquainted with it, because his son did some of his medical training there.

Mr. Chairman and members of the committee, my name is Henry Manning, and I am president of the Cuyahoga County Hospital System. It is a system that is made up of a large teaching hospital as its core, as well as a very large rehabilitation hospital and a 350-bed extended care facility. We provide a very large range of services to all the citizens of Cuyahoga County, especially the indigent.

The issue that this committee is considering is a major social issue in Cleveland, and indeed, the State of Ohio. There are frequent editorials throughout our State, and a wide-ranging debate as to possible solutions to a problem that is clearly growing and one which threatens the viability of some of our hospitals, particularly in Cleveland.

I happen to represent a very successful hospital in the field of indigent care. Our primary mission is the care of the indigent. On the other hand, we have in our institution managed to also engage in sufficient private practice and care of insured patients, so that in the past we have been able to do quite a lot of so-called cost-shifting to insured patients and people who are able to pay their bills.

By some estimates, our hospital system provides 50 percent of all the indigent care in Cuyahoga County. Obviously, we are not the only actor, as that number reflects. There are four other major hospitals in Cleveland, inner-city teaching hospitals which together provide another 40 percent of all the indigent care.

Beyond that, there are a number of neighborhood clinics, such as the Free Clinic, which is a very admirable eleemosynary facility, which do a very large job in providing care to the poor. And there is also Hough-Norwood, which is a federally-chartered neighborhood health center, as well as the Visiting Nurse Association, a very important actor, and others.

The four principal hospitals that share the basic burden with our hospital are university hospitals, Mount Sinai, St. Luke's, and St. Vincent Charity. All five of us are inner-city hospitals, and we are all engaged in teaching programs.

I was interested in the testimony just before me on the issue of "dumping." I think Cleveland has been rather fortunate, as I believe Senator Glenn would observe as well, in that we have, perhaps, a somewhat greater concept of communitywide responsibility. The hospitals collectively have shared more, and we have not seen the kind of dumping at my hospital that has been referred to at the Cook County Hospital. I am grateful for that, as the administrator of the county's only public hospital.

As I mentioned earlier, we have in the past been able to finance a lot of care for the poor by cost-shifting, that is, setting our rates and charges at levels that are higher than actual costs. To the extent that insurance companies will recognize the cost of charity care, bad debts, or other losses, and will also recognize margins, we have in the last decade been able to generate quite a lot of money to help pay for indigent care. Consequently, we have also been able to maintain fairly level requirements on the taxpayers, in terms of subsidies for the hospital. Our appropriation from the taxpayers of Cuyahoga County is actually, on an inflation-adjusted basis, quite a lot lower now than it has been at any other time.

As a result, we have been able to successfully combine local appropriations and charges to insured and paying patients to work for the benefit of the poor and services to the poor.

I would like to emphasize the declining capacity of hospitals to carry out that kind of dynamic in financing the needs of the poor. There is a tremendous amount of restructuring of the health industry underway, as the committee is quite aware, and there is also a tremendous amount of restructuring of the health insurance markets, as one of the earlier witnesses testified. This restructuring is driving price competition in hospitals to a fierce degree. Price competition implies, of course, that a hospital must be as cost effective and operate as efficiently as possible and avoid any unnecessary costs that it can.

Therefore, the price competition strategy is directly impacting on our continued ability to finance services to the poor, because we have used cost shifting quite widely to finance a lot of this care in the past. The dynamics of the marketplace are simply squeezing out the previous ability of hospitals to have margins that might be used to finance these services.

Inner-city hospitals and teaching hospitals are particularly hard hit. Inner-city hospitals are generally located in large population areas that have the greatest proportion of poor and near-poor folks in their immediate surroundings. Teaching hospitals are caught in the squeeze because the cost of teaching is high, yet only through teaching do we have the manpower to provide services to the indigent poor—through interns and residents. As cost pressures descend on hospitals, the ability to finance that manpower, that staff, comes under increasing pressure. Price competition is driving teaching hospitals to reconsider how many interns and residents they can afford to have in their emergency rooms, clinics, and so forth.

I do not want to go on too long. The message I would like to convey is that, while price competition in the health care industry is accomplishing many good goals, it has also set up a dynamic which is quite dangerous to some of the social needs of people, particularly to the continued ability of large teaching hospitals to maintain adequate staff to serve as a resource of last resort in providing care to the poor.

We need to come up with solutions to this problem, because if we do not, I do not believe that we will much longer have a system that permits both price competition and gains in the overall health care in the country. I simply do not think the two are going to go hand-in-hand unless we can solve the side effect that I have spoken about, the problem of financing the health care needs of the poor.

Thank you, Senator, for inviting me.

Chairman HEINZ. Thank you, Mr. Manning. I note also that you have a prepared statement which is quite complete, and that will be included in the record in full.

[The prepared statement of Mr. Manning follows:]

PREPARED STATEMENT OF HENRY E. MANNING

Mr. Chairman and members of the Senate Special Committee on Aging: My name is Henry E. Manning. I am President of the Cuyahoga County Hospital System in Cleveland, Ohio, a position in which I have served for the past 15 years. I appreciate this opportunity to comment on the growing problems confronting our hospital. These problems are certainly not unique to us but rather are the outgrowth of a variety of major developments affecting health care providers across this nation, particularly those serving a large number of indigent patients, as we do.

Our Hospital System provides the broadest array of health care services of any institution in Northeast Ohio, a full range of inpatient, outpatient and outreach social services. Our modern facilities serve more than 2,500 people a day and provide a single, high standard of quality care to all who use our services, regardless of their financial means. Those who are insured and able to pay are expected to pay and do so.

Specifically, our Hospital System consists of Cleveland Metropolitan General/Highland View Hospital, a modern facility with 549 acute care beds, 172 rehabilitation beds and a comprehensive outpatient service which last year logged 335,000 visits in our 98 primary care and speciality clinics. The System also includes Sunny Acres, a 320-bed skilled nursing facility; the Kenneth W. Clement Center for Family Health Care, a satellite primary care clinic serving Cleveland's inner-city population; and the Chronic Illness Center which provides in-home support for the significantly disabled and frail elderly.

Our Hospital System is a major regional medical center, housing Cleveland's only Burn Center and Spinal Cord Injury Unit, as well as one of two newborn intensive care units in the metropolitan area. The hospital also operates Metro LIFE FLIGHT, a comprehensive emergency air transport service, providing helicopter and jet transports 24 hours a day to and from more than 40 hospitals in Northeast Ohio.

To operate this complex network of health and human services programs, the Hospital System employs more than 4,500 physicians, nurses, health professionals and support staff. The medical programs of the hospital are administered by a highly competent and skilled group of physicians and dentists who serve on the faculty of the Medical and Dental School of Case Western Reserve University. In addition to their patient care responsibilities, our staff teaches medicine and surgery to forty percent of the medical students at the University and trains more than 200 resident physicans each year.

As President of the Hospital, I am proud of our record of recruiting and retaining a broad range of talented administrators to a county-owned public hospital. Among our ranks we have more than 20 men and women with advanced degrees in hospital and health care management.

The citizens of Cuyahoga County take pride in their public hospital system and have regularly supported our call for tax levies for construction and operating funds. The system is managed by a ten-member Board of Trustees selected and appointed pursuant to public statutes and broadly representative of the citizens of the County. The Trustees serve six-year terms without compensation.

The leadership of the Board of Trustees, the support of the Board of County Commissioners, and the high caliber of the hospital's professional staff have made it possible for this public hospital to develop and progress so that today it is one of the stronger public hospitals in the United States. Our dedicated work force is fully capable of carrying out the missions that we have designed for ourselves and our facilities are technologically modern and cost efficient.

I have described these various attributes of our Hospital System in some detail, not as a commercial, but so that the Members of this Committee will have a better sense of the type of institution that today is finding itself in grave danger of precipitous economic decline. Our hospital's continued capacity to carry out its historic missions is in real jeopardy due to changes in the health care and health insurance industry that tend to deny all hospitals sufficient payment and operating margins to carry the cost of unpaid services for the poor. There are a variety of factors currently at work which combine to make our challenges more formidable than at any other time in the last 30 years. I would like to briefly share with the members of this Committee some of my perceptions as to what those factors are—and what might be done to mitigate against the special problems being experienced by our hospital and others that serve large numbers of medically indigent patients.

First and foremost, I should mention that, the Medicare prospective payment system has created a whole new mentality and morality of price-driven competition in health care services. Providing care to those unable to pay is a cost that must be included in prices charged by hospitals. In many hospitals striving to hold down costs in order to succeed in today's price competitive environment, service to the poor is being increasingly rationed.

Changes in the financing of health services in the private sector have further complicated this situation. Many industrial employers have restructured employee benefits to put more burden on employees to shop for lowest-priced health services and to use hospitals which have entered exclusive arrangements with the employer to provide services at low rates. While such arrangements may be in the best interest of the employer and the employee, they obviously also serve to compel hospitals to squeeze cost margins in order to survive economically. Indigent care is a cost that is identifiable and therefore quite vulnerable to being squeezed out.

During the last year or two in Cleveland, there have been dramatic changes in the dynamics of the health care market. For example, last fall Blue Cross and Blue Shield of Northern Ohio, the largest health insurance carrier in the region, instituted compulsory bidding by area hospitals for continued provision of services to Blue Cross policy holders. This unprecedented competitive bidding initiative forced hospitals to ratchet down their prices in an effort to hold on to Blue Cross business, which once again resulted in many hospitals having diminished capacity to finance care to the medically indigent. Simultaneously, other commercial health insurance carriers and health maintenance organizations have initiated aggressive price negotiations with area hospitals for specialty care and other services for their subscribers. It appears that price-based competition is now a firmly established method for purchasing and paying for hospital and medical services and is altering the dynamics of the Cleveland health care marketplace in a way that endangers the provision of services to the poor.

While price competition and marketplace economic theories appear to be having the overall anticipated results within the health care industry as a whole, it is implausible to allow this approach to continue without addressing the undesirable effects on provision of care to the medically indigent. Amidst these new realities of

price competition and brokered purchase of health care services, how can a hospital such as ours plan to finance its indigent care caseload?

County support to our Hospital System has remained static in real dollars for several years now (Attachment A) and has actually declined significantly in inflation-adjusted dollars (Attachment B). In the 1970's when the health care market was growing, the Hospital's declining dependence on county funds was quite acceptable. But today, with less and less of the cost of indigent care financed from operating margins and with federal and state reductions in Medicaid and other health care programs, our Hospital must now look to the County for greater contributions. Unfortunately, in Cuyahoga County, as in most of the nation's large urban centers, a shrinking population base, difficult economic times, and the federal government's effort to shift responsibilities to the local level, combine to create heightened demands on the County treasury and a diminished ability to help meet the medical care needs of the county's poor.

As a result of this dilemma, the County Commissioners earlier this year named a broadly-representative citizens' task force to look at these issues and to propose new approaches for seeking to assure care for medically indigent county residents. It is too early to tell what the task force will conclude, but the gravity of the problem and the paucity of viable solutions is quite apparent to me.

Hospitals in the Cleveland area and elsewhere in the country are not alone in struggling with this question of how to pay for health care services urgently needed by individuals who themselves are unable to pay. Earlier this month, I received a letter from the president of the Visiting Nurse Association of Cleveland (Attachment C) asking that I work with her to help find ways for the Visiting Nurse Association to cope with the large number of indigent patients to whom they provide home care services after referral from our Hospital and others. Their dilemma, too, is that endowments, grants and other sources of funds are proving insufficient to assure the continued availability of needed services to the poor.

Everyone is aware of the difficult budgetary and policy issues currently confronting the Congress. At the same time, I hope that the members of this committee, and in the Congress as a whole, will be sensitive to the deep-seated problems that threaten the ability of the health care industry to meet the basic health care needs of our citizens. Important questions are currently before the Congress which have the potential to further exacerbate the situation, especially for urban hospitals and the population they serve. I have reference specifically to S. Con. Res. 32 and the proposal therein to reduce Medicare and Medicaid support for the cost of medical education and the proposed reduction of $1.2 billion in federal expenditures for the Medicaid program. Both of those proposals target service to the poor, the first jeopardizing the medical manpower situation in teaching hospitals and the second by reducing funds for state Medicaid programs.

These direct hits on the flow of federal funds, together with the general freeze on Medicare payments and the 1986 transition year to national DRG payment rates, translate to a projected loss in 1986 of more than $6 million for our Hospital System (Attachment D). Further difficulties will result for us if our county government finds itself unable to provide at least the same level of subsidy to us as in the current year. While Cleveland Metropolitan General Hospital at the Cuyahoga County Hospital System has steadily grown in its capacity to provide medical care to the poor, the outlook today is that our capacity in 1986 and thereafter will rapidly deteriorate.

Mr. Chairman, I would like to conclude my statement to the Committee by saying that while I represent an urban public hospital that has in the past been well supported by its community and has been relatively successful in serving the community, I foresee serious future economic problems for us. Both the County Hospital and our partners in the private sector are faced with rising cost pressures and growing numbers of people who cannot afford to pay for necessary medical care and at the same time are not eligible for Medicaid or other payment programs. As I have discussed this morning, with private payors less willing and local government increasingly less able to assist in the financing of indigent care, the ability of the County Hospital to absorb larger portions of the indigent caseload is clearly in doubt. We hope that the Congress will not act to exacerbate this problem but will instead vigorously seek ways to alleviate this serious situation.

Thank you.

ATTACHMENT A

CUYAHOGA COUNTY HOSPITAL SYSTEM

Annual Comparison of County Appropriations and Total Receipts

Consolidated

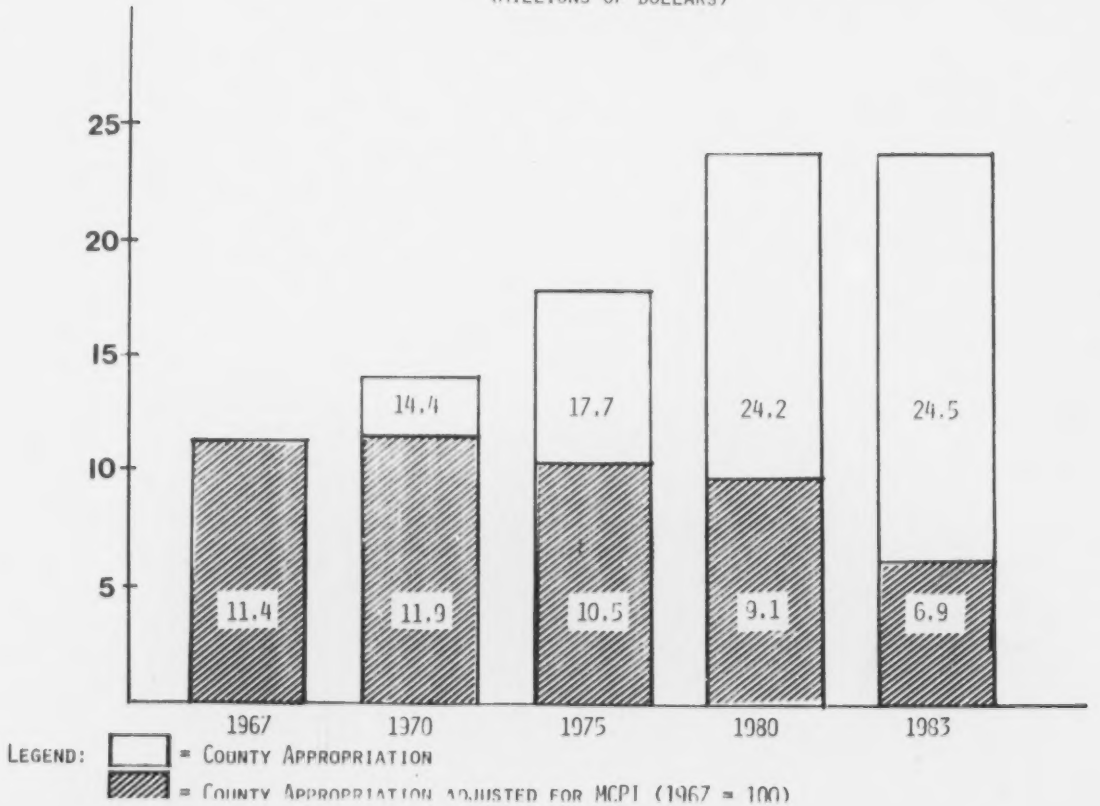
Years 1966 - 1985

Year	Receipts	County Appropriation	Appropriation as % Receipts
1966	$ 22.7 million	$10.5 million	46.3%
1967	$ 26.2 million	$11.4 million	43.3%
1968	$ 29.8 million	$11.7 million	39.2%
1969	$ 33.8 million	$13.4 million	39.8%
1970	$ 37.3 million	$14.4 million	38.7%
1971	$ 41.3 million	$14.1 million	34.2%
1972	$ 44.2 million	$15.6 million	35.3%
1973	$ 48.4 million	$16.2 million	33.4%
1974	$ 54.4 million	$17.1 million	31.5%
1975	$ 61.7 million	$17.7 million	28.6%
1976	$ 71.3 million	$17.9 million	25.0%
1977	$ 74.4 million	$18.1 million	24.3%
1978	$ 84.0 million	$19.0 million	22.6%
1979	$ 87.0 million	$23.2 million	26.6%
1980	$104.8 million	$24.2 million	23.1%
1981	$121.8 million	$25.4 million	20.9%
1982	$143.2 million	$24.5 million	17.1%
1983	$149.5 million	$24.5 million	16.4%
1984	$166.2 million	$24.5 million	14.7%
1985	$168.3 million	$24.5 million	14.6%

RLC/kmj
2638D

ATTACHMENT B

COUNTY APPROPRIATION TO CCHS
ADJUSTED FOR INFLATION
(MILLIONS OF DOLLARS)



JUN 1 3 '85

Visiting Nurse Association of Cleveland

ATTACHMENT C

ADMINISTRATIVE OFFICES
3300 Chester Avenue
Cleveland, Ohio 44114
(216) 432-0700

PATIENT SERVICES CENTRES
Heights Centre
2480 Lee Boulevard
Cleveland Heights, Ohio 44118
Ohio City Centre
1702 West 28th Street
Cleveland, Ohio 44113

June 3, 1985

Mr. Henry E. Manning
President
Cuyahoga County Hospital System
3395 Scranton Road
Cleveland, Ohio 44109

Dear Mr. Manning:

Few individuals are more fully aware than you are of the impact that indigent care needs have had on Greater Cleveland's health services systems. The commitment that you and the County Hospital System have made to help meet the needs of those who are least able to advocate for themselves is exemplary. It reflects an earnest effort to keep faith with the citizens of Cuyahoga County, who count on "their hospital system" to provide essential health services.

Like many other local institutions, the VNA, its Board and administrators have undertaken a thorough evaluation of the indigent care perspectives that apply to us. The conclusion we have drawn is that the VNA must strictly control the amount of "charity care" we provide so that it does not exceed the annual funds available for such care. We anticipate that we will be able to provide $715,000 in indigent care this year. This sum, derived from United Way allocations, endowment income, and community gifts, will comprise 13.5% of our 1985 budget.

In reviewing this issue we determined the specific amount of indigent care the VNA has rendered to patients of each area hospital. Our records indicate that we provided $96,048.00 in unreimbursed care to patients referred by the Cuyahoga County Hospital System during the six-month period through March, 1985. Monthly allocations were as follows:

October	November	December	January	February	March
$21,655	$16,190	$14,973	$14,500	$16,335	$12,395

These figures indicate a 33% indigent reimbursement mix for patients referred to the VNA from the County Hospital System.

Unfortunately, such an indigent care mix is significantly above that which the VNA can absorb. This is a matter of great concern to our Board of Trustees.

Our Board believes that there are a number of potential options which can help ameliorate the impact of indigent care referred by the County Hospital System. We would, of course, be grateful to work with you and your staff to implement a system which operates to our mutual benefit and satisfaction.

Please understand that we appreciate your strong commitment to help meet our community's indigent care needs. Our own commitment is likewise strong, and we intend to pursue such avenues as will permit us to maximize our provision of indigent care while maintaining our financial viability.

Because of our concern, we would like to meet with you. Please contact me at your earliest convenience. I look forward to hearing from you.

Thank you for your kind consideration.

Very truly yours,

Gloria Pace King
President and
Chief Executive Officer

GPK/sah

VISITING NURSE ASSOCIATION / CUYAHOGA COUNTY HOSPITAL SYSTEM

Reimbursement Mix Analysis
10/84 through 3/85

	In Patient	Out Patient	Total
Medicare	54%	39%	51%
Blue Cross	3%	2%	3%
Other 3rd Party	3%	2%	3%
Medicaid/Welfare	29%	51%	34%
Indigent	11%	6%	9%
Total	100%	100%	100%
Indigent	30%	40%	33%
Reimburseable	70%	60%	67%

NOTE: 78% of VNA services were provided for inpatient referrals.
22% of VNA services were provided for outpatient referrals.

ATTACHMENT D

ESTIMATED MEDICARE REDUCTIONS
WHICH IMPACT ON CCHS
(MILLIONS OF DOLLARS)

• FREEZE ON DRG'S	- $ 1.0 MILLION
• TRANSITION TOWARD NATIONAL STANDARDS	- $ 1.9 MILLION
• FREEZE ON DIRECT MEDICAL EDUCATION	- $ .3 MILLION
• CUT IN INDIRECT MEDICAL EDUCATION	- $ 3.0 MILLION
TOTAL ANNUAL REDUCTION IN 1985-86	- $ 6.2 MILLION

Chairman HEINZ. I would like to welcome back to the committee Prof. Uwe Reinhardt, of Princeton University. Professor Reinhardt, I know you have an 11:30 plane you have got to catch. I think there will be plenty of time, however, for your statement and any questions.

So please proceed. It is nice to have you back.

Dr. REINHARDT. Thank you, Senator Heinz, and your colleagues on this committee.

The last time I had the privilege of testifying before this committee, you commiserated with me for having to eke out a living at Princeton, rather than to flourish at Yale. I now would like the record to show that although I teach at Princeton and have come to love it, I also have great affection and admiration for Yale. As we all know, great things come from Yale, not only DRG's. And to demonstrate my sentiments on this issue, I would like to submit for the record a T-shirt I have brought you, which says that, "On the eighth day, God created Yale."

Senator GLENN. Neither one of you were fortunate enough to go to Muskingum College. [Laughter.]

Dr. REINHARDT. But I should add that Princeton archeologists say that Princeton already stood on the sixth. [Laughter.]

Chairman HEINZ. Without objection, your T-shirt will be entered into the record as an archeological exhibit.

STATEMENT OF DR. UWE REINHARDT, PRINCETON, NJ, PROFESSOR, PRINCETON UNIVERSITY

Dr. REINHARDT. I would like to thank you, Senator Heinz, and your colleagues on this committee for inviting me to comment on the problem of the medically uninsured in this country. It is truly a vexing problem, and without any doubt, the central issue of American health policy today.

As an economist, I feel almost out of place at this kind of hearing, because the problem we are confronting is not an economic one; it is a moral one. Let me explain what I mean by that.

Let us step back a bit from the American health care sector and peer through the money flows at the real resources that are there. We will then discover a truly peculiar situation—one that would be humorous were it not so sad.

On the one hand, the United States is now beset by a surplus of physicians nationwide, certain pockets of shortage aside. We are also literally drowning in acute-care hospital beds. We have surpluses all around—in the pharmaceutical sector, in the hospital supply sector—wherever you look in American health care, we have a surplus of real resources just waiting to be employed.

On the other hand, there is now ominous talk of a need to ration health care. In this context, of course, the word "ration" is just a polite code word. As any of the cogniscienti in this game know only to well, the word really means that needed health services are to be denied poor fellow Americans who are unable to pay for these services.

In other words, it seems increasingly accepted in our society that we now need to ration resources of which we have too many. That is odd, it is silly, it is sad, and it is outrageous.

I invite you to travel in Europe, in Canada, in Japan, or anywhere else in the world, and to explain that situation to a foreigner, that is, that America now needs to ration resources of which it has too many! Yet that is the problem we confront at this time.

Strictly speaking, an economic problem is one that involves the allocation of scarce resources to alternative ends. A problem that leads us to deny surplus resources to needy fellow citizens is not an economic one. It is a moral problem, a crisis of the American spirit. I would like to illustrate that assertion with a few examples.

I, personally, do not endorse the fee freeze imposed by Medicare. I see it as a purely political gesture, with only minor budgetary or economic significance. Even so, whatever one may feel about the fee freeze, when the highest paid profession in this country now claims that because of that fee freeze, it will decline to treat the aged and create two-tiered health care, we have here, with all respect, a crisis of that profession's spirit. Physicians are telling us plainly that they need to be paid to be decent. In my book, that is a moral crisis.

Similarly, it is now clear that in spite of DRG's and all the noise about prospective payment, hospital profit margins have never been as high in the last 20 years as they were in 1984 on average—although our municipal hospitals on whom both the for profit and nonprofit hospitals increasingly dump uninsured, poor patients are clearly an exception to this pattern. It is also true that most of our hospitals have very low occupancy ratios. I would submit, with all respect, that an industry beset by high profit margins and low capacity rates suffers a crisis of the spirit when it achieves these profits by dumping poor sick patients. It is a moral crisis, not an economic one.

And finally, this country has a lower tax rate than any other industrialized nation—with the exception of Japan. We spend a smaller proportion of the GNP through the public sector than any other industrialized nation, including Switzerland. Furthermore, that percentage has been virtually constant—about 33 percent—throughout the 1970's.

If taxpayers in such a country are unwilling to underwrite the health care of their poor fellow-citizens, that country as a whole suffers a moral crisis, and such a people, such taxpayers, it seems to me, are faking nationhood when they light firecrackers on July 4th. Are we really a nation, or merely a geographic convenience?

In short, then, the issue we are facing is a political and a moral one, and not one forced upon us because we do not have enough resources to meet the health-care needs of all American people.

For more than a decade, we have looked down our nose at the British health system because that system has had to ration health care. That system's penchant for rationing has only recently been described, with barely disguised disdain, by two American authors (see Henry Aaron and William Schwartz, "The Painful Prescription.") But the British ration in a peculiar way. By an openly democratic political process, they decide the capacity to be put in place, for the health sector—its physical capacity. Then, it is up to the physicians to use medical judgment to ration that capacity on the basis of medical need and age. I do not advocate that system for the United States because, rich as we are, we do not need that

kind of stringency in this country at this time. But at least the British system is an open, democratic system, one that is based upon a shared social ethic and one that seems to be respected by the people.

I would argue that the British style of rationing operates on a morally superior plane than ours—a system that would deny the needy patient access to health care within sight of an idle doctor and within sight of an empty bed, and solely because that patient is poor and not insured. That kind of rationing upon which we now seem to be embarked strikes me as rationing on a lower moral order.

I believe, or at least I hope, that once this problem is clearly understood by Americans, they will address it properly. The role this committee can play in making that problem understood is crucial, and that is why I congratulate you and, as a citizen, thank you for having these hearings.

I do not want to go into the many stories of denied care that one could cite—anecdotal evidence and mere systematic survey evidence. For example, the Robert Wood Johnson Foundation found that in 1982, 1 million American families were denied access to health care for want of money, because they were unable to pay.

Some of my colleagues in economics have responded to this survey with the remark: "Wow, only a million! That is really not a big problem given the size of our population." My reaction to that response is threefold. First, if it is such a small problem, why don't we take care of it? Second, 1 million is a lot of people when you happen to be one of them. Third, only a very few American hostages are taken per year, too, and yet we are concerned about them, rightly so. If it is reasonable to have a whole Nation concerned over a mere 40 hostages in Beirut, why is it silly to worry about 1 million Americans who are hostages to illness and poverty?

One may ask, how did this great Nation get into this fix? After all, the American people are not an evil people. To a European of World War II vintage, Americans, in fact, revealed themselves as a very generous people. It is not for lack of good intentions. As Senator Glenn pointed out to us earlier, the Nation has for 20 years been trying to wrestle with this problem.

As I analyze this issue, the problem stems from the fact that we have tried to package two opposing value systems into one health care sector. On the one hand, we tried to be completely egalitarian on the distribution side by seeking to reach a state in which there would be no financial barrier between patients and health care providers. Furthermore, we have insisted that there be complete freedom of choice among providers. That is total egalitarianism. Every politician in this country has at least paid lip service to that principle.

On the other hand, however, this country has never had the political will or ability to issue, along with this egalitarian urge, the regulation of providers that egalitarianism in distribution always implies. If you want an egalitarian distribution of anything—wine, loafers, bread, or health care—you must regulate the providing sector. We have not been able to do in this country, for better or for worse.

On the provider side, we have been purely libertarian. Any physician could practice any way he or she wanted, and charge anything he or she wanted for medical services. Any hospital could capitalize itself any way it wanted and get retrospectively reimbursed for any cost that could be reasonably linked to health care—pure libertarianism on the provider side. Now, when you try to extract an egalitarian distribution of health care from libertarian producers, you inevitably pay a pretty penny, because you must then hand the providers, literally, the keys to the sundry collective treasuries of Blue Cross, of commercial insurers, and of the U.S. Treasury. That is, in fact, what we have done, and that act of faith has now driven up the cost of health care in this country to levels that are unimaginable elsewhere in the world.

To balance the budget under our system we have simply excluded millions of Americans from access to this otherwise fine system. For the poor, nothing but the best, we have said. And if the best was too expensive, we simply gave the poor nothing. That, I believe, is how we got into the present fix. We tried to do what mankind has never been able to do since the fall from grace: We tried to avoid trading off the providers' freedom for the sake of equity in distribution. We tried to have it both ways—and we wind up with a quite unseemly mess.

Now, how do we get out of this mess? I think to get out of it, we must acknowledge that we will have a multitrack health care system in this country, at least for a while. Now, it is actually multitiered. Politically, however, you would not want to call it that; you would call it multitrack or some other camouflaged code name, because multitier does not sell very well in the political arena; the term might shatter illusions. I am firmly convinced that the champions of the poor may have asked for more equity in human services than this body politic seems willing to deliver. That is true, incidentally, in education, as well, and in jurisprudence. We operate multitiered systems there, too, with superior ones for the rich than those for the poor. We are a society that "tiers" these human services systems as a matter of course. That much should be acknowledged openly.

Once we have acknowledged openly that we are committed to two- or multitiered human services systems, we can then concentrate on implementing policies to safeguard the quality of the bottom tier and to finance that tier. That will be the object of public health policy in the end—letting the rest of the system—the private part—go its own way. We may think of the best attainable American health system as a three-class system, one with tourist class, business class, and boutique class health care, the latter reserved for yuppies and super-annuated yuppies like myself.

In the short run, what can the Federal Government do to develop the bottom tier? I think in the short run, the Federal Government probably can at best facilitate initiatives in that direction at the State and local level, and I understand that you are introducing a bill designed to do just that. That is, in the short run probably the only thing that can be done at the Federal level.

In the longer run, I do see a role again for the Federal sector, because moral leadership in a nation ultimately has to come from that level if we want to think of ourselves as a nation on days

other than the Fourth of July or on days when Americans are held hostage somewhere.

For example, at some time in the future the Federal Government ought to mandate health insurance—at least minimally catastrophic health insurance—but with catastrophes defined so that American families do not get pauperized over illness.

But if one mandates the health insurance, one must then also make it available to the citizenry. Our insurance industry has always been structurally impotent to provide this coverage. It ultimately requires legislative action. To that end, I would advocate that the Federal Government becomes the health insurer of last resort, that it provide a standard policy which every American has a right to purchase. The price of that policy to the individual family could and should be made a function of family income. The whole thing could probably be worked out through the Federal income tax system.

Such an approach will obviously cost Federal money. We could, of course, raise taxes to finance these outlays, which I think this country will do in any event, when the present, almost incomprehensible postering over the deficit has come to an end. We will probably be spending 36 to 37 percent of the GNP publicly before long. It is now about 33 percent.

Alternatively, we could redirect health care expenditures we already are making. For example, we could tax employer-paid health insurance benefits which accrue primarily to middle and upper middle class in many ways, and redirect those resources to the poor. I, for one, would be happy to have my Princeton-paid policy premiums so taxed.

Finally, we may well have to ask our well-to-do aged to pay more for their Medicare coverage and redirect those resources toward the Nation's younger poor. That is an issue the aged will have to discuss among themselves. Do they or do they not wish to practice a bit of noblesse oblige in this arena.

Whatever method we use to finance health care for the poor, there will have to be prudent purchasing. It cannot be open-ended procurement, as it used to be. We have a surplus of doctors and a surplus of hospitals. It is a unique opportunity for the Government to exert its market muscle and to bargain for prices—to bargain hard, and to force providers to price their services competitively. To achieve that market muscle, however, the Government must ultimately constrict the choice of providers enjoyed by the poor and the aged, by servicing them through health maintenance organizations or preferred provider arrangements of some sort. That is the inevitable price, of greater market power in health care and it is that restriction of choice that leads me to speak of a multitier system. The bottom tier need not be poor quality if we pay attention to the quality of care, monitor it, and pay providers reasonable levels of capitation. In any event, such a system would be better than the uncertain or absent coverage the poor now have, and their continued reliance on the noblesse oblige of kind-hearted providers. We are not talking about reaching an egalitarian utopia. We merely need to beat the present disgraceful system to do better, and that should be easy to do.

Thank you.

Chairman HEINZ. Thank you, Professor Reinhardt. That was a marvelous and powerful statement, and I think Senator Glenn and I will have plenty to discuss with you, after we hear from our next witness, Patricia Butler.

[The prepared statement of Mr. Reinhardt follows:]

[Oral testimony resumes on p. 68.]

PREPARED STATEMENT OF PROF. UWE E. REINHARDT

(Published in Center for National Policy, *Health Care: How to Improve It and How to Pay For It*, Washington, D.C., April, 1985.)

HARD CHOICES IN HEALTH CARE: A MATTER OF ETHICS

(By Uwe E. Reinhardt)

The American health care sector today finds itself in the midst of a revolution that has cast health-care providers and policymakers onto opposite sides of a battle line.

Providers believe that policymakers seek to constrain health-care expenditures without any regard to the quality of care. Policymakers, on the other hand, believe that the providers' manifest concern over quality is just a smokescreen put up to defend a habit of reckless spending (and opulent lifestyles) without regard to economic efficiency. At the moment there are recriminations all around and nary an attempt at constructive dialogue.

The current battle follows a decade or two of dreams and delusions during which both parties to the fray seem to have believed sincerely that a nation which defied the laws of gravity to go to the moon could also defy the most fundamental laws of economics. We thought health care could be distributed fairly without any form of rationing.

If one were to describe the thrust of American health policy during the past two decades, one would say that Americans sought to develop in those decades a health care system that would, *simultaneously*:

obviate the need to ration health care by price and patients' ability to pay,

obviate the need to ration health care by queue;

obviate the need to ration health care by administrative decree;

obviate the need to influence the behavior of patients and health-care providers through government regulation;

encourage the development of technological advances in medicine and their rapid diffusion in health care;

encourage patients and providers to use health-care resources efficiently.

In reality, of course, that wish list was never fully achieved. There always was some rationing by price and ability to pay; there always was some rationing by queue; and there always was some sporadic, fainthearted government regulation. The point is that none of these were ever viewed as acceptable—particularly government regulation—and that the search continued for the perfect system.

To anyone familiar with the rudiments of economics, this wish list appears both touching and troubling. It is touching because it seems so exuberantly well-intentioned. It is troubling because it adds up to an act of self-delusion. That delusion has been that the nation could sidestep the need to ration health care by one means or the other.

Grand delusions of this sort inevitably evoke rancor when reality finally intrudes upon them. In the present instance, that reality is a health-care system that is one of the most expensive in the world. At its best, it also may be unrivaled in the world in terms of effectiveness, but for the bottom fringe of our nation's income distribution, it is increasingly a system to which they have no access. This result is that American health care is beginning to generate a series of disgraceful vignettes of the following variety, all taken from reputable sources:

A woman enters a private hospital to give birth. In the delivery room, she mentions to her doctor that her husband has recently lost his job and with it, his health insurance. Whereupon the doctor sends her—*in mid-labor*—to the county hospital catering to the area's poorer residents.[1]

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[1] Linda Demkovich, "Hospitals that Provide Uncompensated Care are Reeling from Uncompensated Costs," *National Journal*, November 24, 1984; p. 2245.

A public clinic refers a desperately ill baby to a regional medical center for treatment. The baby's parents are indigents and have no family doctor. After waiting in the medical center's emergency room for four hours, the baby is finally admitted by a radiologist. The pediatrician on call had refused to treat the baby on the grounds that he did not want to serve as back-up for a "free clinic". The baby dies a few hours after admission.[2]

A 35-year old woman sustains massive trauma in an automobile accident. A primary-care physician stabilizes her and seeks to refer her to the care of a neurosurgeon at the tertiary care center of a privately endowed university. When the neurosurgeon hears that the patient has no insurance coverage, he refuses to accept the transfer, because he had previously gotten into trouble with the hospital administration over his admission of a critically ill, uninsured patient.[3]

A woman is two months' pregnant when doctors tell her that complications require surgery. She and her husband, who earns $9,600 a year at a tire-service center, do not have the $500 down payment that uninsured patients must make prior to admission at the nearby hospital. A month passes before the money is raised. In the meantime, the woman bleeds internally and suffers a great deal of pain.[4]

A pediatrician in a Rock Hill, S.C., hospital wants to transfer a comatose three-year-old girl to a better-equipped urban medical center. But her family has no health insurance, and two hospitals refuse to take her. A hospital 100 miles away finally accepts her.[5]

Ironically, these vignettes emerge against the back-drop of widespread excess capacity in the health care sector. In response to a physician shortage perceived during the 1950s and 1960s, the nation more than doubled the capacity of its medical schools and encouraged the immigration of thousands of foreign-trained medical graduates. At this time we are abundantly supplied with physicians, and it generally agreed that there will be an outright surplus of physicians during the 1990s. There is, in addition, a nationwide surplus of hospital beds. Indeed, it is not inconceivable that on the same day and in the same city, parallel conferences might be held, with the following titles:

Rationing of health resources and the quality of health care

The physician surplus and its implication for the quality of health care

The problem of excess capacity in the hospital sector

How has a nation that prides itself on "Yankee ingenuity" come to find itself facing the necessity of rationing resources of which it has too many? The problem seems perplexing if one assumes that the nation wishes to distribute these resources on the basis of medical need. On relaxing that assumption, it becomes perfectly understandable that a nation may worry, simultaneously, about the impact of rationing and the impact of surplus capacity in health care. The two impacts occur on different positions of the nation's income distribution. We are about to curtail the access of poor and near-poor persons to health care. Their health status may suffer thereby. The owners of the resources freed in this manner, however, are sure to redeploy them in order to earn an income with them elsewhere. That "elsewhere" will be the upper reaches of the nation's income distribution. Individuals in that part of the distribution may be overserved by health care providers—they may fall victim to needless surgery, for example—and their health status may suffer thereby as well; hence the worry about the impact of a physician surplus on the quality of patient care.

Viewed in this light, then, our dilemma in health care is not primarily an economic one. It is, in essence, a moral one. Unlike most other nations in the industrialized world, we have not yet reached a consensus on the ethical precepts to be imposed on the distribution of health care among members of society. Unfortunately, to this day we have not even mustered the courage to discuss that troublesome issue in open debate, presumably because it is so delicate. And therein lies the confusion and the impotence of this nation's health policy.

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[2] Sara Rosenbaum, "Testimony of the Children's Defense Fund Before the National Council on Health Planning and Development on 'Uncompensated Care in a Competitive Environment: Whose Problem Is It?' " October, 1984; p. 9.

[3] Keith Wren, M.D., "No Insurance, No Admission," *New England Journal of Medicine*, February 7, 1985; p. 373.

[4] *Business Week*, February 18, 1985; p. 59.

[5] "Hospitals in Cost Squeeze 'Dump' More Patients Who Can't Pay Bills," *Wall Street Journal*, March 8, 1985; p. 1.

COMPETING GOALS IN HEALTH CARE

The American wish list set forth above can be distilled into three distinct goals which one may pose for a nation's health system:

that the health system provide all citizens "equal access";

that the providers of health services be free from government interference into decisions about producing and delivering health services, and how to price these services;

that there be budgetary control over health care expenditures.

Table 1 presents these goals on one dimension of a grid. The other dimension arrays the major prototypes of systems which address such goals.

TABLE 1:—COMPETING OBJECTIVES IN HEALTH CARE: BASIC PROTOTYPICAL SYSTEMS THAT SPAN THE SET OF ACTUAL SYSTEMS

Desiderata			
Egalitarian distribution	Freedom From Government Interference in pricing and in the practice of medicine	Budgetary and cost control	Prototypical system.
Yes	Yes	No	The Health-Care Provider's Dream World.
Yes	No	Yes	A National Health Insurance System with Fee Schedules and Other Utilization Review. (e.g., Canada, West Germany).
No	Yes	Yes	A Price-Competitive Market System.

An argument implicit here is that one can attain any two of these goals in their purity, but not all three. We are forced to choose pairs of these goals, or we must be content with imperfect attainment of all three. For example, we could muddle through by allowing some degree of inequity in access, and by constraining to some degree the freedom it provides to practice and to price new services as they see fit.

Most industrialized nations of the world have tended towards the second row of Table 1. They have put a high premium on what they refer to as "solidarity." In the context of health care, this term implies that there be health care of a politically-determined level of quality available to all citizens on dignified terms. By "dignified terms" is meant that access to that health care is a basic right, regardless of ability to pay.

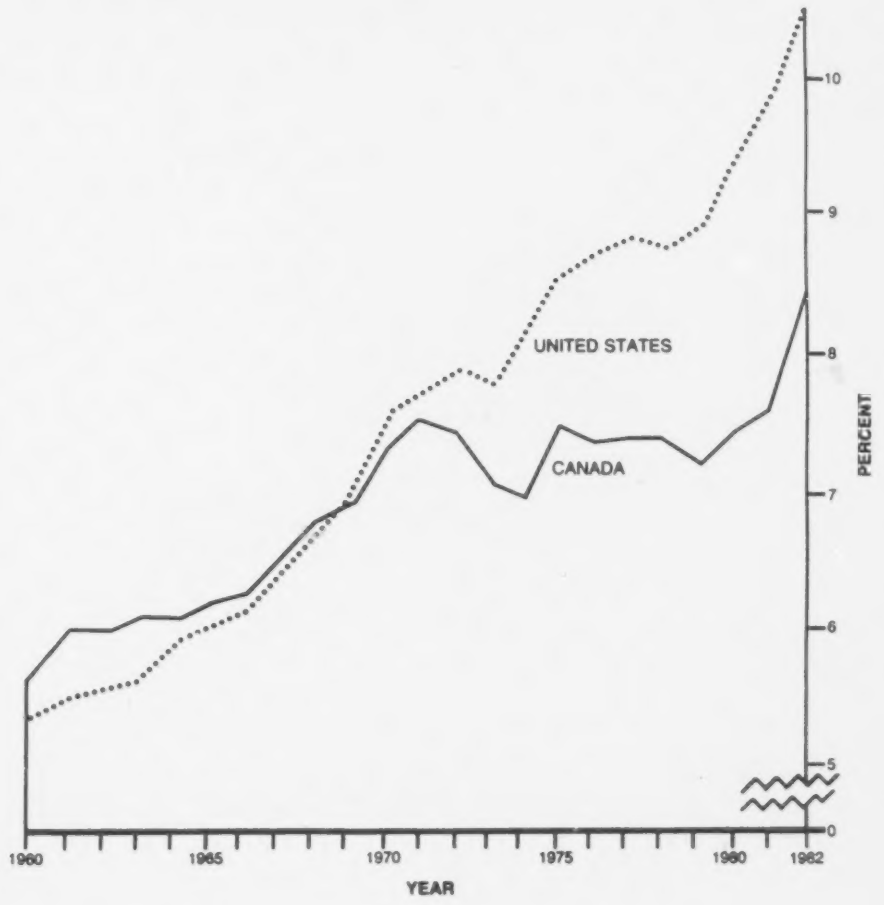
To pursue this goal and to exercise control over health-care expenditures, these societies have found it necessary to constrain at least the economic decisions of health-care providers, and sometimes even their medical decisions. In neighboring Canada, for example, physicians are bound to predetermined, negotiated fee schedules, and hospitals must operate within predetermined, overall budgets. Within these constraints, however, both types of providers are free to practice medicine as they see fit. By contrast, in England and in several Scandinavian countries there are, in addition, direct constraints on the style of medical practice.

Because of the constraints these nations place upon their health-care providers, they have been able to guarantee every individual access to a broad range of health services, spending in the process a much smaller percentage of their gross national product on health care than does the United States. In Canada, for example, that percentage has been about 8 (see Figure 1 below); in England, it has been about 6. In France, it is about 8 and in West Germany, about 9.5. In the United States, that percentage is now close to 11.

Figure 1

HEALTH EXPENDITURES AS PERCENTAGES OF GROSS NATIONAL PRODUCTS, CANADA AND UNITED STATES, 1960-1982

1981 AND 1982 FOR CANADA ARE PROVISIONAL



Source: Canada, Department of National Health and Welfare, *National Health Expenditures in Canada, 1970-82*, Ottawa, 1983, Figure 3, p.9

It must be added that in almost all countries with national health insurance, a small fraction—usually well-to-do individuals—do opt out of the nationalized system to procure health care on a private basis. In the United Kingdom, for example, about 5 percent of the population choose that route. The percentages are similar in West Germany, in France and in the Scandinavian countries. In Canada that percentage is miniscule. By and large, then, it is accurate to say that for the overwhelming majority (usually more than 90 percent of the population), countries with national health insurance systems guarantee that majority access to a one-tier health system as a matter of basic right, and without any regard to ability to pay. The problem of "uncompensated indigent care" simply does not arise in these countries.

It must also be added that nations with national health insurance systems have found it necessary to encrust their systems with fairly rigid codes. In contrast to the United States, where innovation in the delivery of health care is the order of the day, these nations can hardly be said to be innovative in the organization of health services. The high degree of egalitarianism they espouse does come at a price. That price may even include lower *clinical* quality of health care, as American observers are wont to argue—although that belief is not universally shared. West German physicians, for example, claim for their own the title of "best health care system in the world."

During the decades following World War II, repeated attempts were made to introduce a national health insurance system in the United States. These attempts failed. The American people were warned by health-care providers—physicians prominent among them—that national health insurance represented "socialized medicine" and would inevitably lead to expensive, low quality care. Many other commentators, health-economists prominent among them, concurred with this prognosis. "If you like our postal system," they argued, "you'll just love National Health Insurance." So far, this line of reasoning has carried the day in this country's political arena and, for better or for worse, it will continue to carry the day for at least the remainder of this decade, if not this century.

An objective policy analyst cannot naysay such a social choice, as long as its consequences are clearly recognized and accepted. But are they? One suspects that health economists arguing against national health insurance knew full well that tacitly they were advocating a two- or multi-tiered health system in which health care would be rationed at least in part by patients' ability to pay. Economists have no problem with such a world because they deem it efficient and, one suspects, because they tend to fare well in it themselves. But did our health-care providers fully appreciate the implications of their own political rhetoric?

Judging by the rhetoric—"the best health care for all Americans," and so on—it would appear that providers sincerely believed in the feasibility of row one of Table 1—a paradisical dreamworld in which physicians, hospitals and patients would be free to select the treatment for a given medical condition, leaving it to someone else tactfully to pick up the tab, without ever raising a question about (1) the composition of that treatment or (2) the prices charged for the services going into that treatment. To raise questions about either the treatment or its cost, it was held, would be an intolerable intrusion of bureaucrats into the patient-provider relationship. It was deemed un-American. In other words, American health-care providers appear to have persuaded themselves, and their allies in sundry legislatures, that one could actually extract a perfectly egalitarian distribution of health services from a perfectly libertarian production system!

And libertarian that system has been, the perennial laments by health-care providers over government regulation notwithstanding. For example, the United States is virtually the only country in the world in which the individual physician is still free to set his or her fees at will, on a patient-by-patient basis, subject only to the constraint of the marketplace. Not surprisingly, the fees charged by American physicians are high, as can be inferred from the comparative data in Table 2. On average, physicians in Canada are paid only about a third of the fees customary in the United States for similar procedures. Table 2 makes a point often overlooked in our debate on health policy. Our system not only encourages the massive application of real resources to those medical cases it accepts for treatment. It also makes rather generous money transfers per unit of real resource (e.g., per hour of physician time) to the owners of these real resources.

TABLE 2—COMPARISON OF UNITED STATES AND CANADIAN MEDICAL FEES, 1984

	Prevailing charges under Medicare (California)	Median fees United States	Fees in Ontario, Canada
Electrocardiogram (professional charges only)	$40	$35	$7
Insertion of a pacemaker	1,815	1,200	$334
Appendectomy	734	600	$259
Extraction of lens	1,341	.....	$368
Hysterectomy	1,393	901	$503

Source: U.E. Reinhardt, "The Compensation of Physicians: Approaches Abroad," Mimeographed, January 1985, Table 3.

By international standards, the American hospital, too, has been remarkably unfettered. In most other countries, the individual hospital is subject to fairly strict regional planning, and its revenues are constrained *ex ante* through fixed *per diem* rates or prospective global budgets.[6] No other country has been content to reimburse hospitals on a passive, full-cost retrospective basis, as has been the case in the United States until the recent introduction of some private and public payer contracts. To be sure, we have seen some feeble attempts to regulate capital formation in the hospital sector, or to disallow certain hospital charges for reimbursement. By and large, however, one would not be too far off in describing the social contract with American health-care providers over the past couple of decades as follows:

To the extent that health services were insured, third-party payers (both private and public) told providers to do for the patient whatever they deemed appropriate and, thereafter, to go to a collective insurance treasury, there to scoop up whatever monetary reward they, the providers, deemed "customary" and "reasonable."

That this arrangement turned out to be expensive should surprise none but the hopelessly naive. Indeed, what may surprise one is that the arrangement did not cost more! One need only imagine what regular businesses or, say, investment banks would have done had they been issued a key to sundry collective treasuries. (We can get a clue by observing the behavior of defense contractors.) What, one may ask, stopped the system from going through the roof altogether?

One explanation might be that our health care providers truly have been reasonable—that they were driven by other than pecuniary motives and this saved the treasury from earlier exhaustion. An equally and perhaps more compelling answer, however, is that, long before health-care expenditures had a chance really to go through the roof, parts of the American health care sector veered from the drive toward the paradisical row one of Table 1 straight down into row three (the market approach). Even during the heyday of the Great Society, the United States never did depart fully from rationing health care by price and private household budgets, as other nations had done long before. In fact, Americans are far less extensively insured for health-care expenditures than is widely supposed. Tables 3 to 5 speak to this point.

TABLE 3—PERCENTAGE OF INDIVIDUALS WITHOUT HEALTH INSURANCE UNITED STATES, 1977

Income adjusted for family size	Number of persons (thousands)	Percentage in income group uninsured	
		Uninsured some of the time	Always uninsured
Poor	26,534	13.6	14.5
Near poor	9,320	11.4	14.0
Other low income	34,270	9.9	12.3
Middle income	78,455	6.4	7.6
High income	63,519	4.8	4.9
All incomes	212,098	7.6	8.7

Source: National Center for Health Services Research, National Medical Expenditure Survey, 1977.

[6] Global budgeting refers to the approval of an overall budget which leaves the manager of the hospital the freedom to allocate funds to live items.

TABLE 4—HEALTH EXPENDITURES BY SOURCE OF PAYMENT (SAMPLE OF 14,000 U.S. FAMILIES, 1977)

Type of service	Percentage of Bill Paid By	
	Family out-of-pocket	Third party (insurance or other)
1. Ambulatory physician care	59	41
2. (All physician services)	34	66
3. Dental services	80	20
4. Prescribed medicine	80	20
5. Repair of glasses and contact lenses	91	9
6. Medical appliances and supplies	79	21
7. Inpatient hospital care (excluding physician service)	12	88

Source: Kasper, et al., "Expenditures for Personal Health Services." Findings from the 1977 National Medical Expenditures Survey. Mimeographed paper, presented at the Annual Meeting of the American Public Health Association, November 1980.

TABLE 5—TOTAL HEALTH CARE EXPENDITURES FOR PERSONS AGED 65 AND OVER BY SOURCE, 1981

[Dollars in billions]

		Percentage from each source			
		Private	Medicare	Medicaid	Other
Total expenditures	$83.2	36	45	14	5
Hospital care	36.6	14	74	4	8
Physician care	15.6	42	55	3	
Drugs and sundries	5.1	82		16	2

Source: U.S. Senate, Special Committee on Aging, "Medicare and the Health Costs of Older Americans: The Extent and Effect of Cost Sharing," 98th Congress, 2nd Session; Washington, D.C., 1984; p.2.

As these displays indicate, only hospital services are more or less fully insured in the United States. But hospital services constitute slightly less than half of total national health care expenditures. By contrast, ambulatory physician services are rather poorly insured. On average, patients appear to pay about 60 percent of expenditures on ambulatory physician services directly out of pocket. Dental care, prescription drugs and other health services are even less well covered. Overall, American patients still pay for about a third of their health care directly out of pocket at point of service. Thus, it is simply not correct to assert that price no longer plays a role in the distribution of health services in the United States.

Many Americans have no health insurance coverage whatsoever. The actual number of such persons tends to fluctuate over time with economic conditions, for it is a feature of our economic order that employees who lose their jobs typically lose their health insurance coverage as well. As a rule of thumb, however, one can say that roughly 10 to 12 percent of the American population—or between 22 to 25 million people—are without any health insurance coverage at any point in time. Most of the uninsured belong to low-income households.

As poor, uninsured persons have fallen seriously ill we have not, of course, let them languish in our streets. Usually we have treated them, whereafter we have tried to recover the cost of their treatment first from them and, failing that, from other paying patients via a process known to health-care providers as "cost shifting." A distinguishing feature of this approach—one that separates the United States from virtually all other nations on earth—is that the uninsured receive such care in the form of unpredictable noblesse oblige on the part of some provider, rather than as a matter of entitlement. Depending upon one's social ethics, one may or may not judge access to health care on these terms "dignified." In any event, the very nature of this noblesse oblige is apt to have acted as a rationing mechanism in American health care.

This peculiar and uniquely American approach to indigent care was kept ethically bearable as long as the reimbursement system for paying patients was so open-ended that the cost of treating the uninsured poor could easily be passed on to the paying patients. This now much maligned process of "cost shifting" actually served as the fig-leaf that covered up what would have otherwise revealed itself to the world as a national disgrace.

The fig-leaf, alas, appears to be slipping. It is being dislodged by the price-competitive pressures now beginning to manifest themselves in American health care. The days of passive, full-cost retrospective reimbursement for hospital services and of "usual, customary and reasonable" (UCR) compensation of physicians are numbered. Gone are the times when Americans trusted health-care providers so freely with the nation's resources.

Starting in October 1983, the Medicare program began to compensate hospitals at prospectively set, nationwide, administered prices per medical case on a take-it-or-leave-it basis. It is a safe bet that, also before long, that program will scrap the time-hallowed UCR system and compensate physicians on the basis of fixed fee schedules or even on the basis of medical cases. It is possible that the DRG system for hospital care will eventually give way to an alternative, simpler method of compensating hospitals—perhaps to predetermined per-diems or even to global budgets. In any event, it is a safe bet that any such system will be (a) prospective and (b) based on regional averages that abstract from the individual hospital's own cost experience.

It must be expected that the private health insurance sector will follow suit in this reimbursement reform. After all, behind that sector stands the business community which now absorbs about $100 billion annually in health care expenditures through employer-paid health insurance premiums for employees. Until very recently, corporate managers had paid scant attention to this type of expenditure. It was therefore quite easy to pass most of the cost of treating uninsured indigents through to the business community's payroll accounts via commercial health insurance premiums. For this type of cost shifting the days seem numbered as well. More and more businesses now actively seek to extract price concessions from health-care providers through arrangements known as Preferred Provider Organizations (PPO's). Under these arrangements, employees are steered, through financial incentives, toward "preferred" providers who have agreed to make price concessions and, typically also, to exercise economy in the prescription of medical procedures.

Where PPO's fail to yield the desired economies, the business sector can always resort to the ultimate weapon in its cost-containment arsenal: contracts with Health Maintenance Organizations (HMOs), under which the HMO agrees to deliver comprehensive health services in exchange for a flat prepaid annual fee per patient at risk. Under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, prepaid contracts with HMOs were legitimized for the federal Medicare program as well. Where such an approach is based on price-competitive bids among competing HMO's in a given area, it constitutes the ultimate flexing of market-muscles by the purchasers of health services.

Whatever the particular acronyms in this "medical alphabet soup" may be, their objective is always the same: so-called "prudent purchasers" of health services with market power seek to extract price concessions from providers so that the prices paid are above incremental costs but below fully allocated costs. The name of the game is to convert the payment for all health services—not just the cost of indigent care—into a hot potato, so to speak, which is passed on from one payer to the other through the process of "price discrimination" (a.k.a. "cost shifting").

Price discrimination is a strategy by which payment for the fixed costs (and profits) of producing a good or service is extracted predominantly from those purchasers who are unable to resist higher prices. It is a strategy of "greasing the wheel that squeaks the loudest and of plucking the goose that squeaks the least," so to speak. Such a policy is a natural feature of a price-competitive market in which the fixed costs of producers are high in relation to variable costs—even if only in the short run—and in which consumers cannot resell the services produced. Airlines and hotels widely practice this pricing strategy. It will be a prevalent feature of American health care in the future.

Because there must be a limit to the ability of even weak purchasers of health care to absorb costs shifted their way, however, collectively the purchasers of health care clearly seem bent on transferring fewer dollars from the rest of society to health-care providers as a group, leaving the providers to fight among themselves for their share of the reduced, aggregate transfer. It is not a pastoral world, and not one in which nice providers necessarily finish first. Furthermore, the game is bound to squeeze out the erstwhile cross-subsidies by which paying patients were made to cover the cost of treating indigent patients and by which American society assumed the appearance of decency.

The irony inherent in this development is not easily overlooked. Having led the good fight against "socialized medicine" for three long decades, our providers of health care seem to have backed into that meat grinder otherwise known as the price-competitive health-care market. It is a new world, one in which health services

are "product lines," patients are "customers," and health-care providers are forced to behave like regular commercial enterprises merely to survive. Physicians, in particular, seem to be bewildered and alarmed by this turn of events, for they are learning quickly the general definition of a competitive market: it is an arrangement whereby the provider's life is made tough so that consumers can live comfortably and cheaply. But what else did physicians expect when they fought National Health Insurance?

PRICE-COMPETITION AND THE QUALITY OF HEALTH CARE

We have now driven the cost of health care to the point at which we are reluctant to purchase that expensive commodity for our poorer brethren. Providers have contributed to this outcome by the rhetorical arsenal they have deployed in the political arena. In the face of any proposal to control the cost of health care, providers have tended to hurl across the appropriate legislative chamber two concepts to have our policymakers run for cover. These verbal projectiles were "the quality of patient care" and "two-tier health care."

Cost control, it was argued, would inevitably reduce the quality of patient care. Wealthy Americans would use money to bribe their way around cost-control barriers to high quality care. Consequently, only the poor would put up with the constrained lower-quality tier. Since two-tier health care is un-American, went the final blow, clearly so must be cost containment. Far better, argued our health care providers, to keep the system open and affordable through "voluntary cost-containment efforts" on their part. Utterly persuaded by this line of reasoning, Congress bought "voluntary efforts" of various sorts, and also appropriated ever larger sums of tax monies to pay for the system.

For over a decade, these rhetorical weapons reigned supreme, devastating even the feeblest attempt at cost containment. In the hard-nosed climate of the 1980s, however, the themes from the 1970s are losing their punch. Rather than simply hurling such slogans at the legislators' viscera, our providers now had better learn to discourse *intelligently* about terms such as "quality" and two-tier health care, lest their concerns in this area be overlooked altogether. After all, thoughtful persons have long appreciated that there is no tight link between health-care expenditures and the quality of a health care system. Figure 2 below can serve to clarify this point.

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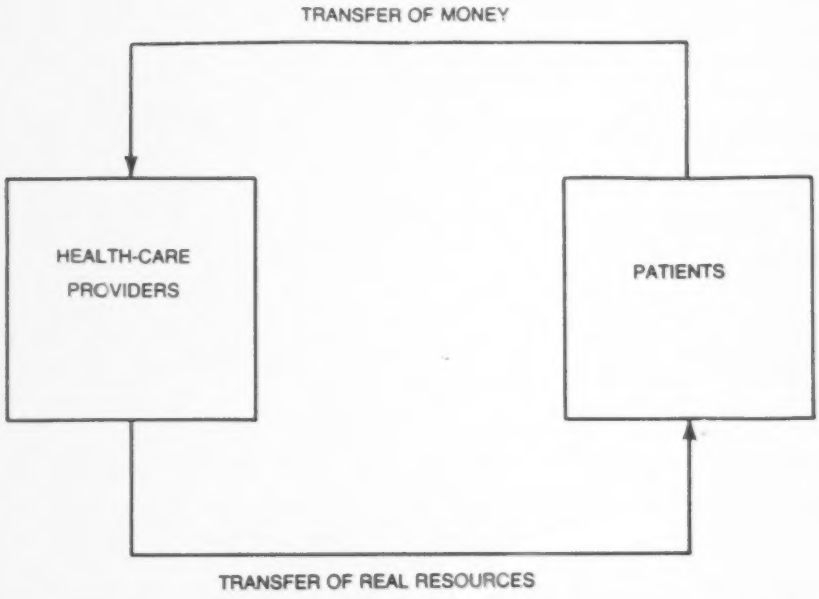
FIGURE 2 REAL-RESOURCE TRANSFERS AND MONEY TRANSFERS IN HEALTH CARE



As already noted, in thinking about the "cost of health care" a distinction must be made between the real resource costs of treating patients and the monetary transfers occasioned by the treatment. The real resource costs of a treatment consist of time physicans and other health workers devote to it, and of supplies, equipment, brick and mortar used up in the process. The monetary costs are measured by the amount of money patients directly or indirectly funnel to the owners of these real resources. Clearly, these monetary costs can rise without a commensurate increase in real resource costs. For example, if a cardiac surgeon decides to raise his or her fee for a coronary bypass from $5,000 to $8,000, only the monetary costs of the treatment rises; its real resource cost does not. This important distinction seems not always as well understood as it should be in debates on health policy.

If a cost-containment measure sought to reduce expenditures on coronary bypasses, the first step might be to roll back the physician's fee from $8,000 to $5,000. The physician's immediate response might well be that the "quality of patient care" will suffer, just as the American Medical Association has recently argued that the fee-freeze imposed by the Medicare program "has forced the nation into a two-tier system of medical care in which Medicare patients have become 'second class citizens.' "[7] What precisely is the public being told here about the professional ethics of American medicine?

Is it the thrust of this argument that, for a mere $5,000 per coronary bypass the physican will do a sloppier job than (s)he would for $8,000? Or is it the point that the physician will henceforth reject any patient who cannot come up with the desired $8,000 in cash and that the patient will thereby be deprived of the physician's (presumably superior) skill? This question is raised here not so much to nettle, as to alert the authors of such statements to the dubious image they project thereby: it is the image of a profession that needs to be rewarded with cold cash for every bit of good it does, and whose professional ethic has a monetary price! Far better to argue that a constraint on physican fees violates principles of a free society, or that pre-

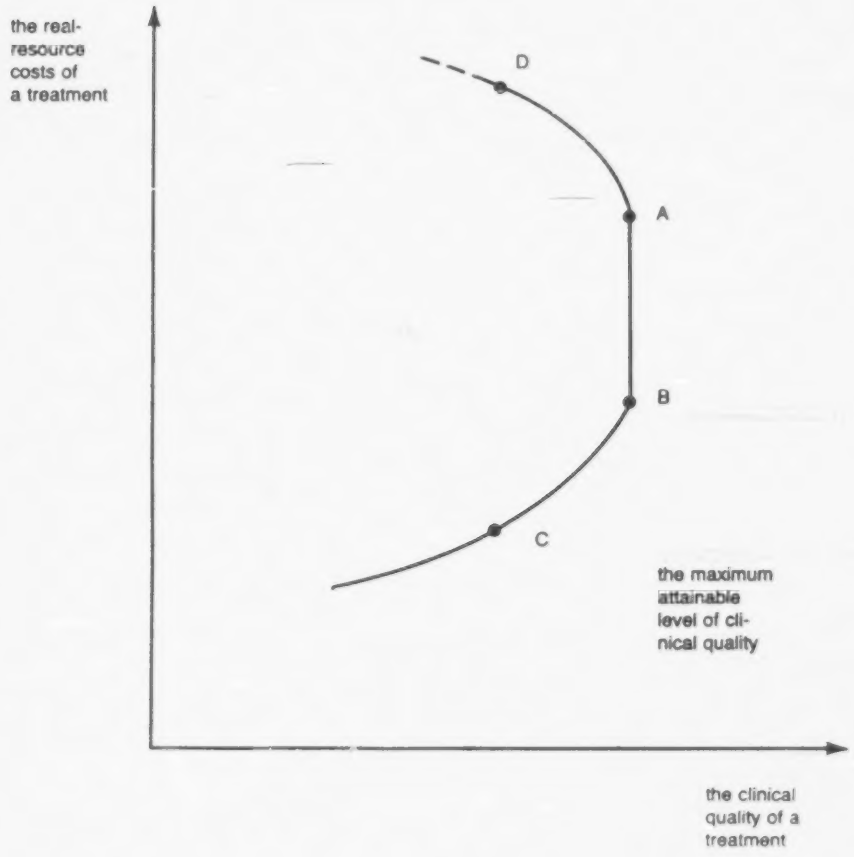
[7] *American Medical News* , January 25, 1985, p. 1.

vailing fees under Medicare are low relative to, say, the fees paid bond lawyers for their simple, routine work.

Let us, next, go beyond mere monetary transfers per unit of health service to the real-resource input per medical case treated. Can we take it for granted that any reduction in the real-resource input of medical treatment necessarily entails a reduction in the quality of care? That there may be such a consequence can be taken for granted. But will it necessarily be so?

For most medical cases, the relationship between quality and cost probably traces out a backward-bending curve such as that shown in Figure 3 below. Shown on the vertical axis of Figure 3 is the total real-resource cost of treating a particular case at alternative levels of "clinical quality," the latter being represented by the horizontal axis. By "clinical quality" in this context we might mean, for example, the probability of recuperating from the condition to a given degree. It can be thought that, up to a point (point B in the diagram) increasing resource inputs (e.g., diagnostic procedures) will increase the "clinical quality" of care, albeit at a diminishing rate of increase. Eventually, however, there must come a point at which further expenditures in resource costs cannot yield further increments in "clinical quality." Between points B and A in the diagram, for example, costs have increased without adding to the "clinical quality" of care. There may even come a point at which further resource-input harms the patient. In Figure 3, that state of affairs is reached on line segment AD and beyond.

FIGURE 3 HYPOTHETICAL TRADE-OFF BETWEEN CLINICAL QUALITY AND COST



Let us assume that the cost-quality trade-off curve in Figure 3 has been pushed as far to the right as the current state of the art permits. We might then raise the following two questions in connection with the argument that cost containment inevitably implies a diminution in the "quality of patient care":

1. Is it alleged by those who make this case that our health system typically finds itself at a point such as B in Figure 3; that is, that our health sector never did expand beyond a point of trivial or zero marginal returns?

2. Even if that were so, would reduction in quality from point B to, say, point C, necessarily be unethical?

Health care is a commodity whose technical quality is not easily assessed by patients. Furthermore, as noted, the cost of some types of health services—e.g. hospital care—is quite well insured for most Americans. Finally, it is the case that our health system is increasingly beset by excess hospital capacity and by a surplus of physicians. Under these circumstances, a move from, say, point B to point A in Figure 3 can certainly not be ruled out a priori. Because one person's health-care expenditure is always some provider's health-care income, a move from B to A in Figure 3 can enhance the provider's quality of life even if it does nothing to enhance the clinical quality of the care received by patients. One need not be a misanthrope to believe that fiscally hard-pressed providers will be responsive to this economic opportunity. One need merely assume that, like everybody else, health-care providers are human.

That this assumption is widely shared in the United States can be inferred from the ever increasing popularity of prepaid capitation for comprehensive health services, an approach that has found favor not only among legislators, but also in the American business community. Whatever polite introduction the advocates of prepaid capitation may give to that approach, they clearly are persuaded that the financial rewards providers derive from composing medical treatments strongly influences that composition—that our health care system has moved much beyond point B in Figure 3 and up the vertical leg of the cost-quality trade-off.

Let us now turn to the question whether it is ever ethically acceptable to reduce health-care expenditures when such actions demonstrably lower the "clinical quality" of care. In terms of the cost-quality trade-off curve in Figure 3 above, the question is whether a move from point B to, say, point C would ever be ethically defensible. Concretely, such a move might mean that one permits increases in the number of deaths per 100,000 admissions for a given illness merely to save money.

Actually, as individual consumers and as a body politic, we constantly make trade-offs of this sort, without any ethical pangs. As consumers, for example, we might opt for small cars to save money even if that increases our risk of injury or death in traffic accidents. Similarly, our legislative bodies routinely refuse funds for projects that might save lives. For example, a town council might vote against outlays for better street lighting fully aware that a number of traffic fatalities could eventually be attributed to that vote. One could even imagine that, on balance, additional lives would be saved if funds were reallocated from the town's hospital to its road department.

Health-care providers find it difficult to apply that line of reasoning to their own context, and for good reasons. First, they are expressly trained to fight at all costs for their patients' lives. Second, while detached policy analysts may find it easy to discourse upon the value of life from a safe distance, no one has yet given the individual physician a publicly sanctioned set of guidelines under which to make cost-quality tradeoffs at the patient's bedside. So far, society has delicately preferred to leave that matter to the pnysician's own conscience and judgment. In other words, physicians can legitimately claim that, while they are perfectly capable, intellectually, of following the economist's stylized illustrations of trade-offs between lives saved on the highways and lives saved in the hospital, as physicians they really do not know how to act on these illustrations at the patient's bedside. As policy analysts we should, perhaps, admit that our exhortations on these tradeoffs have not been particularly well thought out.

The providers of health care must reckon with the prospect that society will increasingly both flagellate them over health-care costs and saddle them with ethical dilemmas no politician (and possibly not even most economists) would have the courage to face in the trenches. With their votes in federal, state and local elections, American taxpayers seem to be signaling more clearly than ever before that they do not wish to be their poorer brethren's (financial) keepers. They would prefer health-care providers to fill that role, as the providers have in the past, and they (or the media) stand ready to complain whenever a provider fails in that role. Unfortunately, no one seems to have figured out how providers can act on noble sentiments

without explicit compensation for their labors. So far, we have left that problem to the providers as well.

TOWARDS HUMANE TWO-TIER HEALTH CARE FOR AMERICANS

Americans often express misgivings over the rationing of health care in other nations, particularly in Great Britain. It is always pointed out that rationing of this sort is the inevitable outcome of "socialized medicine."

Rationing in Great Britain proceeds in two stages. The first stage is a political consensus on the overall resource constraint to be imposed upon the health care sector. That political decision determines the physical capacity available for health care. The second stage of rationing occurs at the level of medical practice. As the process is described by Henry J. Aaron and William B. Schwartz in The Painful Prescription: Rationing Hospital Care (1983), the allocation of scarce physical resources to patients is made by the medical profession. By and large, that allocation seems to have the respect of the populace.

Rationing of health care in the United States is of a quite different variety, because it grows out of a quite different approach to resource allocation. Physical resources, including manpower, can flow freely into our health sector. Furthermore, their owners enjoy a high degree of freedom to deploy these resources as they see fit. As was noted earlier, the flow of these resources has been vigorous, particularly during the decades in which this nation flirted with the costly idea of extracting an egalitarian distribution of health care from its libertarian delivery system. Because health care is now so expensive, we face the problem of rationing access to health resources that are in abundance, if not in surplus. It is one thing to explain to patients that they cannot have a particular procedure because there just is not the equipment with which to perform it. It is quite another to deny the procedure within sight of unused equipment and strictly with appeal to someone's money budget. One might call it rationing of a higher order—"higher order" because its implementation in the trenches requires a special kind of fortitude.

These two different styles of rationing grow out of two fundamentally different perceptions of the role of health care in a society.

In the Canadian and European nations, health care tends to be viewed as a community service whose provision and financing is ultimately the responsibility of the public sector. Access to health care is granted each citizen as a matter of right, to foster the sense of solidarity these nations consider an essential cornerstone of nationhood. To that end, the financing of health care is completely divorced from actuarial principles. The individual's financial contribution to health care is strictly a function of his or her ability to pay and not at all of his or her health status.

As noted, during the 1960s and 1970s, Americans seemed to be veering toward this perception of health care as well, albeit ever so gingerly. Emerging from World War II with the rightly earned self-image of "the most generous people on earth"—a perception that, remarkably, lingers to this day—it was thought that such a people should naturally grant every citizen access to "the best health care in the world."

Few students of this nation would impute that goal to Americans today. It would be more accurate to say that health care is now viewed in this country as a private consumption good whose financing is ultimately the responsibility of the individual. Indeed, when healthy, well-heeled Americans yearn for "actuarially fair" health insurance premiums, they are really communicating that they do not wish to subsidize their poorer, sick brethren through those premiums. Furthermore, with their votes they signal that they are not inclined to replace through taxes the subsidies they are unwilling to provide through insurance. We may still be "the most generous people on earth," but perhaps just not in this area.

The first step towards a more rational—and more humane—health policy would be to acknowledge the emerging social ethic openly and to take it as a given, at least for the time being. The best the poor and their champions could hope for at this stage would be a system of two-class medicine, one for those relying on public financing, and another (or several other classes) for everyone else. Before long, the receipt of numerous novel medical procedures will be tantamount (in cost) to the acquisition of a small BMW, if not a large Mercedes Benz. While the nation's well-to-do will certainly wish to have access to such care, and to pay for it with actuarially fair health insurance premiums, it can be doubted that they will routinely wish to bestow "Mercedeses" of this kind upon perfect strangers whose very poverty raises questions about their social worth in the first place.

A more realistic assumption would be that Americans will wish to treat health care like certain other basic commodities, such as food, clothing and shelter. Ameri-

can society has sought to make basic quantities of the latter available to all of its citizens, but there has never been an attempt to distribute them on an egalitarian basis. Instead, the nation has adopted for them a so-called "basic-needs approach." Even during the heyday of the liberal 1970's, we tacitly adopted the basic-needs approach for health care as well. The poor might have fared better, however, if we had mustered the courage to acknowledge that ethical precept openly and to base our policies upon it.

In the future, our manifest preference for the basic-needs approach in health care will reflect itself in the development of two or several tracks of health care.

At one end of the spectrum, there will emerge expensive, luxurious health care complexes indistinguishable in many respects from luxury resorts. These complexes will be able to attract first-rate medical personnel, just as the nation's prestigious private universities—which also cater disproportionately to the offspring of the well-to-do—tend to attract first-rate scientists. There will be hospitals with exquisite atriums, with gourmet food, personalized services and all of the other good things America's well-to-do enjoy elsewhere in life. We may think of this end of the spectrum as "designer care" or "boutique medicine."[8]

At the other end of the spectrum there will emerge closed-panel delivery systems which in effect will ration health care through limits on physical capacity, just as the British National Health Service does. These systems will deliver comprehensive health services in exchange for prepaid capitation which has either been negotiated or determined by competitive bid. In principle these systems need not give health care of inferior "clinical quality"; they may just lack certain amenities, including the privilege of free choice of physician and hospital. In practice, of course, some of these systems may represent decidedly second-class medicine, particularly if they are run by unscrupulous operators, or if they are seriously underfunded, as at least some are bound to be.

From the perspective of the nation's poor, this choice- and resource-constrained lower tier might represent a decided advantage over the current two-tier system. To the extent that, through application of its considerable market power as purchaser, the public sector could keep the cost per capita of the lower tier reasonably low, society might see fit to grant, at long last, every American guaranteed access to at least this tier as a matter of right. As noted, under the present two-tier system such access is more properly described as unpredictable noblesse oblige on the part of providers. Access to at least something as a matter or right would imply a measure of dignity now absent from our health system. As an erstwhile pauper, this author, for one, imputes great value to that measure of dignity.

Second, a resource-constrained bottom tier would permit physicians to ration health care with appeal to limits on physical capacity. It would spare physicians and hospital administrators the need to deny care to patients within sight of idle resources, merely to defend someone else's budget. Idle capacity elsewhere in the system may not bother the poor if they do not see it. We might just get away with it.

Depending upon one's own social ethics, such a multi-tiered health system may or may not be perceived of as close to the ideal. It does seem close to the dominant social ethic of the day, however, and therein would lie its virtue.

Physicians in particular may balk at the idea of legitimizing a system of two-class medicine. They may fancy that such a system would violate central tenets of their professional ethic. But has that ethic ever played a decisive role in American health policy? As noted, the nation spends close to 11 percent of the GNP on health care now. There is a surplus of physicians and of hospital beds. Yet, with these generous money transfers and with these ample physical resources, the health sector has not so far succeeded in granting all Americans dignified access to needed health services. Whatever the medical profession's code of ethics may be, its role in the distribution of health services has been rather feeble all along. It is probably too late to invoke that code now to stem the forces of the market place.

IN CONCLUSION

It is customary to end essays of this sort with "viable policy recommendations." Readers tend to be frustrated when a diagnosis of social problems is not accompanied by a recommended therapy.

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[8] Marion Ein Lewin deserves credit for fashioning the marvelously descriptive term "boutique medicine."

To be "viable," a therapy should be acceptable to the patient. In the present instance, the question is just what therapy would be acceptable to the American body politic.

The thrust of the preceding analysis has been that the currently emerging problems in America health care are not driven by a scarcity of resources, but by uncertainty over what constitutes a "just" distribution of plentiful resources among members of society. These problems are a product of the nation's soul. As a nation, we seem unable to decide whether access to acutely needed health care is a citizen's basic right, or whether there merely exists an unenforceable moral obligation on the part of providers to render such care. Indeed, we have not even been able to decide just what level of government should define whatever rights there might be to health care in America.

The latter question touches upon the focus of responsibility for providing the uninsured poor with adequate health care in time of need. Is that a federal responsibility? Or is that fully the responsibility of the state or even the local government? To think about that question, we may ask ourselves whether residents of state "X" should worry about the death of American infants in state "Y." If a North Dakotan should care about the health of American infants in, say, Arkansas (and vice versa), guarantees of access to adequate health care would seem to be a federal matter. Conversely, the notion that health care for the poor is purely a state and local matter suggests that North Dakotans have no business worrying about what people in Arkansas do or do not do for American infants residing there, and vice versa. To the best of my knowledge, that issue has never been discussed openly in these terms. It should be.

Until such fundamental questions are openly settled we may, of course, continue to tinker with that ever more wondrous Rube Goldberg contraption called American health policy. We may pool a little revenue in some locality for the uninsured poor, and throw a little local tax money at health care providers in others. Such measures would furnish the grist for quite another paper. The objective of the present paper has been a different one—to explore the nature of the ethical precepts that have driven our health care system in the past and that seem to drive it now. Let the reader judge whether that assessment has been fair and, if so, whether these ethical precepts can serve as a source of national pride.

Chairman HEINZ. Ms. Butler, we want to welcome you. Thank you for being here.

STATEMENT OF PATRICIA A. BUTLER, BOULDER, CO, HEALTH POLICY CONSULTANT

Ms. BUTLER. Thank you, Mr. Chairman.

My name is Patricia Butler. I was the staff director of the Colorado Task Force on the Medically Indigent for about 2 years, and I have been a consultant to the National Governors Association and the National Association of Counties on issues of indigent care.

I want to commend the committee for addressing this problem which Professor Reinhardt has so eloquently described. I am afraid that we are looking today at a problem that is going to be the critical public policy issue of the 1980's, for all the reasons that previous witnesses have mentioned.

I have submitted to the committee a lengthy written statement, and from that, I would like to make three points—first, that the medically indigent are a national problem, but one that is more severe in some parts of the country than others. I think that is very important to keep in mind. When I talk about the medically indigent, I include anyone who is unable, due to poverty, lack of insurance, or inadequate insurance, to afford needed health care.

From national data and several sources, we know a lot about the numbers of the uninsured, and as has been mentioned, those numbers have been increasing. In particular, a very disturbing finding from national data is that fully three-quarters of the uninsured are employees and their dependents—that is of all age groups.

We also have estimates of the numbers of underinsured, and I think it is particularly important for this committee to know that although the age group from 55 to 64 is not as likely as some other age groups to be uninsured, it is the most likely age group of people under 65 to have inadequate health insurance coverage. And obviously, the witnesses who have spoken today illustrate that particular problem.

States vary broadly in the number of uninsured that they may experience, and that is due to two different phenomena. One is that Medicaid programs vary considerably from State to State, as you know. Furthermore, the types of firms and the sizes of firms vary, and there are certain kinds of employers who are less likely than others to offer insurance—small employers, blue collar, service, and agricultural employers.

So that we see, as an example, from the State of Minnesota, only about 8 percent of its population of all income levels is uninsured, compared to a high of 21 percent in States like New Mexico. These differences are due to more generous Medicaid coverage and more employment-based insurance in some States, particularly those in the Midwest and Northeast, compared to States in the South, Rocky Mountains, and Southwest.

Lack of insurance is important, as obviously, the witnesses indicated today, because local and national research has established that it dramatically affects a person's ability to have access to needed health care.

The second point I would like to make is that States are beginning to respond to this problem. In fact, the problem of the uninsured poor, the non-Medicaid poor, has traditionally been a State or local government responsibility, and the enactment of Medicaid did not change that; it simply modified the types of responsibilities that States and local governments have had to undertake.

States have a variety of programs, which are difficult to categorize. I think what is important for the committee to know is that in the last 2 or 3 years, States have become interested in the issue of the uninsured poor, for all the reasons we have talked about—the recession and tightening of government budgets; the trend toward employer self-insurance; the price competition that hospitals have been facing, which limits their ability to provide charity care. And fully half the States have now undertaken and published studies of this problem, which I am sure are available to the committee. Colorado's task force, whose project I directed, was one of the first to do that.

States are undertaking several new approaches. The problem, I think, is so vast and given limited will—although I would agree with Professor Reinhardt, it is not limited ability—I do not see a single solution in the near future. And in fact, States have taken a variety of approaches to attempt to address small pieces of the issue.

There are three areas that they are looking at. The first is expanding their Medicaid programs. It is very interesting—5 years ago, you would not have seen this at all, but in the last 2 or 3 years, nine State's have expanded Medicaid, partly as a result of flexibility in the Federal Medicaid law that now allows adding certain categories of people such as children and pregnant women.

That has been a very important source of health care coverage, but of course, the Medicaid Program is quite limited, and it does not begin to solve the problem, even when States adopt the most comprehensive federally assisted program that they are entitled to do.

Second, States are looking at expanding their existing State-funded programs, and particularly seem to be interested in maternity care, where there is a very large payoff for small State investments. The State of Texas has just passed a package of five bills, including perinatal and maternity delivery services, and Georgia and a couple of other States have adopted more modest maternity care programs.

The third area that States are looking at—which is perhaps one of the more interesting ones, although it has some real limitations—Senator Chiles referred to earlier this morning, and that is attempting to impose obligations on providers, particularly hospitals, to finance charity care. Three States now tax hospitals to do just that. Florida was the first in the Nation to adopt such a tax. West Virginia and South Carolina have just enacted similar laws and will begin assessments this year. Those taxes go into pools which in some cases fund the State's Medicaid Program and in other cases directly fund charity care for the uninsured poor. Texas attempted this session to require as a condition of licensure that all hospitals provide a certain amount of charity care. The State has a very large number of proprietary hospitals, and this has been a particular problem. They came very close to passing that law, but it was recently defeated.

A couple of other States are proposing a slight variation of this theme, which is to define hospital service areas and require that all hospitals either provide charity care in some proportion to their total patient load, or if they fail to do so over the year, pay cash into a fund that is then redistributed to hospitals that are providing charity care.

So you can see that there is a wide variety of experiments under discussion and, in some cases, that have been adopted. I think we are going to see some creative pilot projects going on in the States, and this is very encouraging.

The other problem that States recognize, but have very little capacity to do anything about, is the dilemma of employment-based insurance. As I mentioned, three-quarters of the uninsured in the United States are workers and their families, but because of the constraints of ERISA that we have been talking about this morning, States cannot require employers to offer insurance. Yet with the increasing tendency toward self-insurance, and the fact that many employers have simply never offered insurance and really do not feel that they can do so, financing health care for the working poor continues to pose a major policy problem for the States and the Nation.

The third point I would like to address briefly is what the Federal Government might be able to do to help the States.

I think that it is unlikely that the uninsured poor are going to become a Federal responsibility in the future. I assume that they are going to remain primarily a State or local government obligation. But there certainly are some areas in which the Federal Gov-

ernment can help other levels of government address these problems.

The first and most important is not to cut the Medicaid budget any further. To do so would severely impair the ability of States to cover existing clients and particularly make it difficult or impossible to expand their Medicaid programs. Federal Medicaid financing is a major source of financing care for the currently uninsured poor, especially in Southern States, which get up to 78 percent of the bill paid by the Federal Government.

Furthermore, I would be delighted to discuss in a few moments with Senator Glenn any possibilities of expanding Medicaid further. As you know, the program is currently limited to certain categories of people. There are two basic problems with Medicaid coverage. One is that its income standards, which are tied to welfare levels, are very low, and second, is that it covers now less than half of the people under the poverty line, partly because working couples, children in two-parent families in many States, and single individuals—unless they are aged, blind or disabled—are ineligible for Medicaid. Obviously, if we could restructure the Medicaid Program to cover more of the poor, that would make a tremendous impact on the medically indigent problem.

Another potential area of Federal assistance would be to look at revenue options. As an example, the Federal cigarette tax is destined to expire this fall, and a number of States have been looking to pick that up if it does expire as a source of funds for indigent care programs. We had such a bill in our Colorado Legislature this year, but it was defeated, partially because legislators were very confused as to the status of that tax at the Federal level. Health care may not be the best use of that tax, as there are certainly a lot of Federal priorities for it as well. But as Congress is examining a restructuring of Federal tax programs, it should look at potential sources of revenue that States could use for health care programs. Not all States are in financial jeopardy; Colorado has more financial capacity than it seems willing to devote to this problem, but certainly there are States, particularly in the Midwest, that need help. And Federal exploration of possible revenue sources would be very useful.

Perhaps the most important thing that the Congress could do to assist States in addressing the medically indigent would be to amend the ERISA law. We have talked a lot today about the importance of health insurance continuation and conversion requirements, and although several States do provide those, they have limitations that have been described before. Besides these requirements, however, it is very important that States be given the flexibility to mandate that employers offer insurance to their workers. That may not be something the Congress wants to do itself, in the short run, at any rate. But there are some States, such as New York, which are very interested in such an option. There are a lot of political difficulties at the State level in mandating employer coverage, but amending ERISA would allow States to make a major step toward responding to what appears to be the greatest part of the uninsured problem—which is workers, many of whom are low-wage workers and would probably need some assistance in

paying for that insurance, but who could probably afford to share in part of the cost but have absolutely no opportunity to do so.

I would be happy to elaborate on these comments or my written statements if the committee has any questions, and I would submit the written statement for the record.

[The prepared statement of Ms. Butler follows:]

PREPARED STATEMENT OF PATRICIA A. BUTLER

I am honored to be able to speak to this Committee today about a problem of growing dimensions in the U.S., the problem of this country's "medically indigent," people unable to afford needed health care due to poverty, lack of insurance, or inadequate insurance. I have worked on indigent health care issues for the past 2½ years, first as the staff director to the Colorado Task Force on the Medically Indigent, funded by the Piton Foundation in Denver, and then as a consultant to the National Governors' Association and the National Association of Counties.

Although there have always been uninsured and poor in this country, the medically indigent present a particularly pressing issue today for several reasons: (1) the recession increased the number of poor, unemployed, and uninsured, and the recent recovery has not abated their numbers; (2) due to rapid medical care inflation, health care is less affordable to those of poor and moderate income and harder for public agencies to fund; (3) reductions in federal support for Medicaid and other public health care programs at the beginning of the decade exacerbated the burden on other levels of government; (4) employers have responded to medical care inflation by limiting employee benefits and attempting to control utilization and bargain with health care providers for lower prices; and (5) increasing price competition among health care providers makes them less willing to absorb the costs of charity and shift them to other payers. Thus there is currently great interest in the medically indigent issue among state and local governments as well as the health care community.

I would like to bring three points to the Committee's attention. First, the uninsured and underinsured, especially the poor, are a national problem, although the dimensions of the problem differ among states and regions. Second, many state and local governments are currently attempting to find new ways of financing and delivering care to the uninsured. And third, although primary responsibility for caring for this population will probably remain with states and localities in the near future, there are several specific steps that the federal government can take to assist other levels of government in meeting this serious and growing need.

I. THE MEDICALLY INDIGENT—A GROWING NATIONAL PROBLEM WITH REGIONAL DIMENSIONS

A. National Data

A general picture of the nation's uninsured emerges from several recent sources of national data. (For purposes of this discussion, insurance includes both private commercial coverage and public coverage under Medicaid, Medicare and the VA. According to the Department of Labor's Current Population Survey, the proportion of uninsured Americans under age 65 grew in small but constant steps from 1980 through 1983 (from 14.4% to 16.5%).[1]

Data from a different survey, the National Medical Care Expenditures Survey (NMCES) conducted in 1977 and 1978 are somewhat old, but this study has the advantage of revealing patterns of insurance coverage and medical care use over time. Most important, NMCES points out that while only 12.6% of Americans were uninsured at one point in time, over 8% were completely uninsured during the whole year and over 7% were uninsured part of the year. Thus 16% of the population were uninsured at least part of the year. NMCES showed that certain population subgroups are more likely than others to be uninsured: the poor, persons 18 to 24 years old, racial minorities, rural residents, and residents of the South and West.[2]

Another significant NMCES finding is that although most (91%) working Americans are insured during all or part of the year, over half of the uninsured are employed part-time or in firms that are small, pay low wages, or are not unionized.

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[1] K. Swartz, Urban Institute, "The Changing Face of the Uninsured," presentation to the Association for Health Services Research, June 11, 1984.

[2] K. Davis and D. Rowland, "Uninsured and Underserved: Inequities in Health Care in the United States," 61 Milbank Memorial Fund Quarterly 149 (1983).

And ¾ of all uninsured persons are employees or their dependents. The employed uninsured are more likely to work in blue collar, service, or farm occupations than in white collar jobs.[3] Almost ¼ of the nation's working poor were uninsured during all or part of 1977.[4]

NMCES is also useful because by collecting detailed information about respondents' health insurance policies, researchers were able to estimate the degree to which Americans are underinsured. By their most conservative definition of inadequate insurance (a 1 in 20 chance of incurring medical costs equal to at least 10% of the family's income), researchers concluded that at least 8% of insured Americans have inadequate coverage and the figure could be as high as 25%.[5] Of particular interest to this Committee should be the finding that although persons aged 55 to 64 are less likely than other age groups under 65 to be without insurance at all, they are at the greatest risk of inadequate coverage by all the definitions proposed in this study.

B. Regional Differences

The national data are important to show the larger picture and particularly to show trends over time, but they mask important differences among states. Due to recent interest in the issue of medical indigency, almost half the states have undertaken studies to estimate the extent of their medically indigent populations.[6] Although these data are not entirely comparable due to definitional and methodological differences, they indicate the problem's regional variations.

Among the states that have now completed studies of their uninsured populations are: Arkansas, Colorado. Florida, Georgia, Iowa, Minnesota, New Mexico, South Carolina, Texas, Washington, and Wisconsin. Under the sponsorship of the Piton Foundation, the Colorado Task Force on the Medically Indigent undertook a board research study of the state's medically indigent problem. In addition to surveying physicians, hospitals, county governments, and insurance carriers, the Task Force conducted a statewide household survey of over 1,000 low income families.[7]

Table 1* shows the proportions of the poor and the total populations in some of these states that have been estimated in recent years to be uninsured. The numbers vary from a low of 8% in Wisconsin to a high of 21% in New Mexico. These differences are attributable to variations in scope of public programs and employment patterns. Minnesota, for instance, has a much more generous Medicaid program and more employment-related insurance, compared to New Mexico and Colorado. which have limited Medicaid programs, less unionization, and many small employers who traditionally do not offer health insurance. We learned in Colorado, for instance, that almost half of the working poor were uninsured during the survey and over half were uninsured all or part of the year.[8]

C. Health Care Use of the Uninsured

Whether or not one is insured is important because it dramatically affects access to and use of health care services. A 1982 national survey of barriers to access to health care showed that among the 1.4 million families experiencing illness that caused a major financial problem during the year, families most severely affected were those that were poor, had public insurance or no insurance, had members not in the labor force, or were racial minorities. These same groups predominate within the 4.2 million families needing medical help but unable to get it and the 1.4 million families refused access to health care for financial reasons.[9]

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[3] A. Monheit, M. Hagan, M. Berk, P. Farley, "The Employed Uninsured and the Role of Public Policy," November 1984, National Center for Health Services Research.

[4] M. Berk, "Health Care of the Working Poor," October 1984, National Center for Health Services Research.

[5] P. Farley, "Who are the Underinsured?" November 1984, National Center for Health Services Research.

[6] Intergovernmental Health Policy Project, "A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent," Fall 1984, George Washington University. The authors cite 21 state studies; legislatures in New Hampshire and West Virginia have recently commissioned indigent care studies as well.

[7] Colorado Task Force on the Medically Indigent, "Colorado's Sick and Uninsured: We Can Do Better," February 1984, Piton Foundation, Denver, Colorado.

[8] Colorado Task Force on the Medically Indigent, "Colorado Health Survey," February 1984, Piton Foundation, Denver, Colorado.

[9] L. Aday and R. Anderson, "The National Profile of Access to Medical Care: Where Do We Stand?" 74 Am. Journal of Public Health 1331 (1984).

*See p. 77.

Furthermore, it is clear from more object measures that the uninsured have less access to care: they use fewer health services than the insured, even when health status is taken into account. For instance, the uninsured nationwide are only ⅔ as likely to have physician visits and only ½ as likely to have hospital admissions as the insured.[10] The Colorado Task Force study shows even greater differences between the uninsured and insured poor.[11]

This research shows that the uninsured experience barriers to access that diminish their ability to obtain needed medical care and that the poor are most affected by these barriers. Although public programs over the last twenty years have improved health status and health care use of the poor, gaps remain. The Medicaid program, for instance, due to its categorical limitations, has been estimated to serve only 40% to 50% of persons under the poverty line.[12]

II. STATE RESPONSES TO THE PROBLEM OF THE MEDICALLY INDIGENT

Caring for the uninsured poor has always been a state and/or local government responsibility. Enactment of Medicaid and Medicare modified but did not extinguish this obligation. State and local governments continue to attempt to serve the medically indigent through a variety of programs that can be roughly categorized into three groups: operating public hospitals and clinics that serve the poor; paying private hospitals part of the costs of their "uncompensated care" for low income patients; and financing care through insurance-type programs (like Medicaid) that establish eligibility criteria and pay private sector providers. These latter programs are often operated in conjunction with General Assistance welfare programs. Variations on this category include catastrophic illness programs that assist middle income families with high cost illness and programs for specialized diseases or conditions, such as cancer, kidney problems, and maternity care.

Although these programs have existed in most states for decades, care for the medically indigent is receiving greater public visibility because government budgets have been stressed by medical care inflation and revenue declines during the recession, an increased number of people seeking assistance because of unemployment, changes in employment-based insurance, and federal welfare cuts. At the same time that the demand for health care has increased, hospitals (traditional providers of charity care) are becoming less willing to shift charity costs to other payers since they are trying to become price competitive in the new market-oriented health care system.

State and local governments are therefore exploring new means to finance and deliver care to the medically indigent. While current propoals vary greatly, they fall into four general categories: expanding Medicaid coverage, expanding state-funded programs, imposing charity care obligations on providers, and expanding employment-based insurance. I will briefly describe current state activities in these areas.

A. Expanding Medicaid Programs

Although the Medicaid program is limited by design to certain categories of the poor (elderly, blind, and totally disabled adults and families with dependent children—usually one-parent families), this program has become attractive to states looking for financing options for the uninsured because they can share from 50% to 78% of its costs with the federal government. Therefore, despite some concern about the limited flexibility Medicaid offers, nine states (Florida, Georgia, Illinois, Iowa, Mississippi, Oregon, South Carolina, Virginia, and Texas) have expanded their Medicaid programs in the last three years, to address the needs of some of their uninsured poor. Since poor southern states benefit most from Medicaid's matching formula, it is not surprising that they predominate among the states adding eligibility groups such as medically needy and pregnant women.

B. Expanding State-Funded Programs

States are also expanding their existing state-funded indigent health care programs, and seem to be emphasizing maternity care. States recognize that pre-natal care is demonstrably cost-effective; it has been estimated in Colorado to save $9 in short- and long-term costs of caring for premature, low birthweight and developmentally disabled children for every $1 spent.[13] For many years Colorado has had a

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[10] Supra note 2.
[11] Supra note 8.
[12] Id.
[13] Colorado Task Force on the Medically Indigent, "Background Research Papers," February 1984, Piton Foundation, Denver, Colorado.

state-funded program to pay for low risk deliveries to indigent women in community hospitals. Texas recently enacted a package of maternity and perinatal bills to support care to this vulnerable population. Last year Georgia enacted a law requiring counties to pay for the costs of delivery for indigent women.

Although three states (Alaska, Rhode Island, and Maine) currently fund catastrophic illness programs, the cost of those programs has apparently deterred other states from current serious consideration of that option. State and local governments that operate insurance-type general assistance medical programs or county hospitals are grappling with how to continue to fund them.

C. Requiring hospitals to provide charity care

Since most hospitals have traditionally treated charity patients, they are a prime source to which states are turning for partial financing of indigent care. States with rate setting, of course, do support hospital charity care through the rate or budget review process. The costs of otherwise uncompensated care are distributed to all payors in the system, private insurance carriers, Blue Cross, and sometimes Medicaid and Medicare.

Even many states without hospital rate setting are considering some method of at least partially equalizing the charity care burden among hospitals; states are concerned because the competitive medical care market cannot function if hospital charity care undermines the effort of some hospitals to compete by price or, alternatively, deters all but the public institutions from rendering indigent care. Efforts to create a "level playing field" among hospitals have taken several forms. Florida became the first state in the nation to impose a tax on hospital revenues to create an indigent care pool, which will fund first a Medicaid expansion and then care for the uninsured. West Virginia just enacted a similar hospital tax to fund its Medicaid program. South Carolina will also begin assessing hospitals and counties to create an indigent care fund to be redistributed to hospitals providing charity care.

Other states, such as Ohio and Washington, have developed (though not yet enacted) "care or share" proposals, whereby hospitals in a region are assigned a proportionate share of free care and if they fail to provide it must pay cash into a fund that is distributed to the hospitals providing more than their designated share. Other states, such as Texas (whose bill was recently defeated), have proposed mandating that all hospitals provide a certain minimum level of charity care as a condition of licensure. The District of Columbia imposes charity care requirements as a condition for certificates of need. As a means of financing indigent health care, taxing hospitals is somewhat regressive, since its costs are merely shifted to other payors. Nevertheless, these proposals are attractive because they relieve state budget pressures and can be rationalized as distributing a traditional hospital burden among all hospitals, rather than among a dwindling number of public and non-profit institutions.

D. Expanding employment-based insurance

The final category of state proposals involves employment-based insurance. Many states require that insurers allow employees to convert to individual coverage or continue group coverage upon terminating employment, and these policies do extend the opportunity to buy insurance. But a greater problem is the extent to which employed persons are uninsured. Three-quarters of the uninsured at all income levels are composed of working people and their dependents. Furthermore, about one-quarter of the working poor nationally (and much higher proportions in some states) lack insurance, largely because the employer does not offer it and sometimes because, when offered, employers do not contribute enough toward the premium to make it affordable for low wage employees. (For example, only 78% of employees in firms with more than 50 percent of the workforce at or near minimum wage are offered insurance, compared to over 90% in other firms.[14]

States have limited ability to influence workplace insurance, however, due to the federal pension law, ERISA. The Employees' Retirement Income Security Act preempts state regulation of employee health plans, and has been held to prohibit a state from mandating that employers offer insurance to all employees. Only Hawaii has a statutory exemption to that law. Other states, such as New York, have considered seeking amendments to ERISA. In the absence of such relief, some states have discussed, but not seriously proposed, creating incentives for employers to offer and

[14] A. Taylor, "Employer and Employee Expenditures for Private Health Insurance," Data Preview 7, June 1981, National Center for Health Services Research.

employees to purchase workplace insurance. Guaranteeing workplace coverage would substantially reduce the number of uninsured.

III. FEDERAL ASSISTANCE IN ADDRESSING THE MEDICALLY INDIGENT ISSUE

It does not seem likely that in the near term the federal government is going to take major financing initiative for the uninsured. Federalization of Medicaid and National Health Insurance are not under current discussion in Washington. Nevertheless, there are several important activities that the federal government can undertake to assist state and local governments to address this issue: maintaining the Medicaid budget, considering sources of revenue for states, amending ERISA, and continuing research activities. None of these activities would necessarily have a significant federal budget impact, but they could all be helpful to states.

A. Maintaining Medicaid budget

It is clear that the states are looking to Medicaid to serve its existing clientele and to cover additional groups of the uninsured poor. Further reductions of the federal Medicaid budget will seriously undermine the states' ability to support their poor populations. States have generally worked hard to curb unnecessary Medicaid utilization, eligibility errors, and provider fraud. It will be difficult for them to absorb Medicaid budget cuts without reducing services or eligibility. Fortunately, in its last two sessions Congress has thwarted administration attempts to reduce Medicaid and in fact enacted the Child Health Assurance Program amendments last fall to expand health care access to young children in two-parent working poor families. The battle over Medicaid is likely to recur, however, and it is very important to resist budget reductions that compromise the program's ability to reach the broadest clientele eligible for its services.

B. Expanding State revenue options

State and local governments face a serious problem in developing new sources of revenue for indigent health care. Most feel incapable of financing expanded indigent care programs with current revenue sources. In restructuring federal tax programs, Congress should consider which current sources of federal tax might be turned over to states. Since the federal cigarette tax is due to terminate this fall, several states considered picking up the expiring tax as an additional state tax to fund indigent care. However, the uncertainty over this federal tax's future, has been confusing for state legislatures. Colorado's General Assembly, for instance, defeated a bill to extend the state cigarette tax (and almost double its current indigent care budget) contingent upon the federal tax expiring because legislators could not obtain a clear message on congressional direction. The federal government could play a valuable role in 1) reviewing expiring federal revenue sources that could be used by states and 2) discussing and evaluating new sources of revenue that states could adopt to fund indigent care.

C. Amending ERISA

As noted, expanding opportunities for employment-based insurance would significantly improve the nation's current medically indigent problem. It is likely that many currently uninsured workers would purchase insurance if it were affordable by being offered at group rates with employer-shared premiums. ERISA prohibits states from exercising their initiative to solve local problems by mandating that employers offer insurance and establishing basic definitions of adequate coverage. Given regional differences in the extent of workplace insurance, it might not be appropriate for Congress to impose such a requirement, but Congress should amend ERISA narrowly to allow states to adopt such mandates if local conditions warrant.

D. Maintaining Federal research activities

The type of detailed information disclosed through the NMCES study is invaluable for policy development and planning. It is clear that states must undertake their own research to discover unique local conditions. But federal research leadership and national surveys form the cornerstone of sound policy in addressing issues of health care needs and utilization patterns. Congress should resist attempts to reduce the federal commitment to health services research.

TABLE 1.—PERCENTAGE OF POOR WITHOUT PUBLIC OR PRIVATE INSURANCE

	Below 100 percent of poverty level	All income levels
United States (1983)[1]	35	16.5
Colorado (1983)[2]	40	18.7
Minnesota (1984)[3]	23.3	8.0
New Mexico (1983)[4]	(5)	21.0
Texas (1981)[6]	28	(5)

[1] K. Swartz, Urban Institute. The Changing Face of the Uninsured. Presentation to Association for Health Services Researchers, June 11, 1984.
[2] Colorado Task Force on the Medically Indigent. Colorado's Sick and Uninsured: We Can Do Better and Colorado Health Survey. February 1984.
[3] D. Shreve, Indigent Care in Minnesota: A Case Study. In: R. Curtis, ed. Access to Care for the Medically Indigent: A Resource Document for State and Local Officials. (Academy for State and Local Government, Washington, D.C. December 1984).
[4] Bureau of Business and Economic Research, University of New Mexico. Health Care Coverage and the Medically Indigent in New Mexico. February 1984.
[5] N.A.
[6] Texas Task Force on Indigent Care. Final Report. December 1984.

Chairman HEINZ. Ms. Butler, thank you very much.

Let's pick up for the moment on your very last point, which is that Congress could amend ERISA narrowly to give States more initiative and flexibility. As I understand your testimony, what you are saying is that the reason States do not do this is that ERISA mandates a benefit package that is either inappropriate or too costly——

Ms. BUTLER. ERISA does not have any standards with respect to health plans at all—that is part of the problem. ERISA, was primarily designed, I think, to regulate pension plans, but the law defines health and welfare benefits to include health insurance plans as well. There are no Federal standards for health plans whatsoever, but the existence of the ERISA law has been held by the U.S. Supreme Court to preempt the States from regulating health plans, for instance, from mandating that employers offer health insurance. The only State in the Union that is entitled to do so (by Federal statute) is Hawaii——

Chairman HEINZ. From mandating health insurance coverage.

Ms. BUTLER. Health insurance coverage, right.

And then, what would also be necessary is that States could prescribe a basic benefit package and possibly affordable premiums as well.

Chairman HEINZ. What was the decision, do you recollect?

Ms. BUTLER. No, but I can certainly get you the citation.[1]

Chairman HEINZ. All right. Why don't you get that for the record; that would be extremely helpful.

I want to go back to Dr. Schiff and Mr. Manning, who really testified to a condition that is affecting our public hospitals. In Dr. Schiff's testimony, you had some excellent charts about the people who were being transferred by foot from other institutions. And Dr. Reinhardt was really talking about the hospitals with the high profit margins—he did not have you in mind—that are sending you from their emergency rooms the patients that are, in a certain sense, very unprofitable to treat.

You have described, really, "outpatient dumping," haven't you?

[1] The citation referred to was *Standard Oil of California* v. *Agsalud*, 454 U.S. 801 (1981).

Dr. SCHIFF. Yes; I can elaborate, giving the numbers to fill in the perspective that Dr. Reinhardt gave. In Chicago, the overall city-wide hospital census is 64 percent, which is very low. This is for last year, when the "dumping" problem was really at its peak, which I believe perfectly illustrates the contradiction that he pointed out.

What I would like to say, and I think it directly bears on the focus on these hearings, having to do with a certain group that is very vulnerable, the at-risk group, being the 55- to 65-year old——

Chairman HEINZ. I wanted to ask you what proportion of the people that are coming in are in that group of 55 and over.

Dr. SCHIFF. We looked at that data and what we found was—I can give you the numbers for the record—that the problem was fairly evenly distributed among the age groups. The "dumping" rate turned out to be the same blatant "dumping" rate; it was 11 percent, which was the same as a 12-percent overall rate. So generally, the problem cut across all the age groups.

The thing that I think bears on the concerns of this committee has to do with something that has been taking place which was an experiment, which was a very disastrous one, in Illinois, where the State put a $500 cap on the certain group of Medicaid patients, the general-assistance group of patients. There was a $500 limit for total reimbursement for their hospitalization. As you know, that would barely cover 1 day in the hospital for most admissions. So the hospitals began massively dumping patients who had an "07" on their green card. What I would suggest is that this is a case study, of what happens when a group of patients that suddenly were clearly-definable as being patients at-risk for the hospitals not getting sufficiently reimbursed. And I would suggest that these people were really dumped in large numbers. Our dumping increase was in large part accounted for; we went from 200 or 300 a month, to 700 patients per month dumped, by the general assistance group of patients. It is too bad we cannot line up each of these 700 to hear each of their stories. Many were not given informed consent. It is really a huge problem, in the micro detail at an individual level but the macro issue that I would like to raise is that the patients were a group of people who were easily-identifiable and sorted out by these hospitals, who recognized that it would be a loss for them to take care of them. I suggest that this age group here is at similar risk. As the demography, and particularly their increased medical risk become clearly identified, I think that is something we have not addressed, but not only is this group of people more exposed in terms of their lack of coverage, but this is when people are getting sick. Thus, you can get away in your 30's and 40's without health insurance and not have major problems, statistically speaking, but when you get older, this is when people are more likely to be sick, and with costly illnesses.

So I think, unfortunately, as a lot of the competitive approaches increase, and using marketing skills, the hospitals' consultants will be able to identify these patients on-the-spot in their emergency rooms. I heard recently of a computer software program for DRG's that will give you the patients that you will lose money on, versus those that you will win. Presumably, the idea is to seek out the more profitable ones; I think this group of people is going to be a

marked group of sort of medical "untouchables," maybe not quite as blatant as this "07" Medicaid general assistance group, but I suggest that this is the kind of trend, that the pre-aged may be facing. I hope that the experience is a warning for policymakers.

Chairman HEINZ. Just looking at the group of uninsured who are coming into your hospital, the dumped ones, age 55 and over, are their medical problems more severe or worse than the people that are not, in a sense, being dumped in similar age groups?

Dr. SCHIFF. I can only give you an anecdotal-type impression. The types of illnesses we are seeing in the younger group are more the acute, self-limited, urinary tract infections, things of that nature; women coming in and wondering whether they are pregnant or not. What we are finding in the older age group are people with more serious, chronic diseases.

Chairman HEINZ. I understand that as you get older, you are going to have a more serious set of illnesses. I mean, what you have described in part are people being dumped, outpatient, inpatient, and presumably, you have a population that you treat that have not been dumped; they are your regular customers. And I was really trying to figure out whether you are seeing a sicker group of people that have been dumped, compared to your more or less regular population, or not.

I gather you are saying you do not really have any statistics on that; is that correct?

Dr. SCHIFF. To answer we have to come back to the inpatient population again. The inpatients who are being dumped, again, this is the hard number—and I could give you the exact figures for the record, it is 6,900 in 1983, people dumped, in-patients—in other words, these are official, ER to ER, transferred by ambulance—5,400 in 1984. These patients, I think, are definitely a sick group of people. There is a study that is being completed at our institution that I think will show a substantial mortality rate among these patients. They are certainly sicker than the average patient—as sick, and in fact, sicker, as this data suggests.

The point is, that these are not patients who have very trivial problems that are being transferred. Rather these are patients whose lives are often being risked in the process.

Chairman HEINZ. Professor Reinhardt talked about our multilevel or two-tiered or many-tiered system. Are we developing a two-tier health care system, No. 1—and in my view, it seems obvious that we are—and second, is there a substantial difference in the quality of health care that the lower tier, the tourist tier, as Professor Reinhardt suggested, the economy class tier, is there any significant difference in quality?

Dr. SCHIFF. Well, I would certainly like to think that we are trying our best under the circumstances to maintain the quality of care at our hospitals. But I think it is obvious that, as we see a growing number of patients, particularly the outpatients, being given the same or less resources, that the quality is going to deteriorate.

A 1-year appointment time now, which is what patients are facing for our general medicine clinic, is a lower quality of care. So I think part of the problem in terms of quality just has to do with access. People are having a very hard time getting in.

So, that is issue No. 1. Again, I do not think there is any question that the qualitative aspects of somebody's care who arrives at an emergency room must go through the long ordeal, shipped off to county—they receive, by the way, bills from those private emergency rooms, bills from the ambulance—just in terms of the doctor-patient interaction, which I think is another facet that has not been brought up. What does it mean that residents in training, that professionals in practice are reorienting their attitudes toward patients. Rather than trying to assume responsibility and take care of people, it is a new reality—one where you try to figure out how to get rid of people. How do you measure that qualitative change? Yes I do think there has been a shift. It occurs at a small level every time we argue over the phone about a patient being transferred. By the way, we have only one ground for refusing a patient, and that is if we can assert that the patient's life will be risked; that they might die en route.

Chairman HEINZ. Otherwise, you have got to take them.

Dr. SCHIFF. We must take them. There is no other grounds we have for refusing them. But even in the tug-of-war over that, of course, the residents at the transferring hospital or the private groups that contract out covering emergency rooms are told that their contract depends on not having too many of these patients admitted; so their job, in a sense, depends on their ability to get rid of these patients. Often, they even misrepresent—although this is the exception rather than the rule, but I consider it a criminal offense, saying that a patient has thus-and-such vital signs, does not look too sick, and of course, when the patient arrives, he looks totally different. Maybe something happened in the ambulance, but more likely their bias became one of minimizing how serious the patient was, and I think that does affect the quality of care certainly for this tip of the iceberg population.

Chairman HEINZ. Both you and Mr. Manning's Cuyahoga County Health Care System in effect are somehow delivering health care to a large number, an increasing number of people who otherwise could not get that health care. Who ultimately foots the bill for that health care—either of you—Mr. Manning?

Mr. MANNING. Thank you, Senator Heinz.

What I was having reference to in my statement is that we have tried very hard to avoid having a two-tier system. In other words, we are trying to maintain our insistence on one standard of care for the poor as well as the paying, insured patients. I still strongly advocate that we hold onto that principle because I think it is very important to the health of the country.

But as I was explaining, we have financed our services heretofore through a combination of cost shifting and local subsidies from the county.

Chairman HEINZ. What we have referred to as the traditional Robin Hood method of paying for health care.

Mr. MANNING. Yes, sir. On the other hand, I am not sure that the method should be derided totally because it is also a way of spreading across the entire community this burden.

Chairman HEINZ. But in your own testimony, you explain how that is changing——

Mr. MANNING. Yes.

Chairman HEINZ [continuing]. And the more there is price competition, the more there is bidding, the more there are preferred provider arrangements and so forth. That methodology of cost-shifting is going to be squeezed aside.

Apparently, Dr. Schiff's organization is already seeing the effect of that relatively young system. I guess the question I am asking is, as that takes place, who is going to pay for the care that the indigent, near-indigent, uninsured need? We have a chart up here that shows that 46 percent of the poor and near-poor are covered by Medicaid, and the other 54 percent are not. Who is footing the bill for that? Is the taxpayer still footing the bill for that, somehow?

Mr. MANNING. I think that is exactly the question, because at the same time this old method is leaving us, there is simply not capacity in local government, cities and counties, to pick up that cost certainly in our region.

Chairman HEINZ. Well, someone is paying for it now. Who is that? Dr. Schiff.

Dr. SCHIFF. A lot of the costs are being shifted onto the county, so the county's share of our budget is increasing every year. We previously got more patients who had third-party coverage, be it public, Medicaid/Medicare, private insurance, and again, as the sorting out of patients becomes more effective—thus, as these proposed marketing solutions become more effective, the situation gets worse for the county. We are seeing more and more people. I think the patients are paying.

We have a hospital that was built in the early 1900's. It definitely needs to be replaced. Everyone acknowledges this. The accreditation is in jeopardy. So the future of the hospital and the safety net that county provides is something very much at risk of being jeopardized.

One of the solutions that is currently being implemented, as of June 1, may in fact make matters worse. Being "dumped" to county may become a luxury, as there is an attempt by the State of Illinois to refer patients to private hospitals in the community that are operating at a large deficit. One of our concerns is that this will actually just facilitate a lot of the "dumping" practices.

So, related to the quality of care and the two-tier issue, is the fact that they are trying to redirect patients away from the teaching hospitals, which is where they have sought care to a large extent in Chicago in the past.

Chairman HEINZ. Very well. My time has expired.

I yield to Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

I think the answer to the question, do they get the same quality of care, is a very simple one, where the answer is "No," and anybody that has been in these facilities knows that.

If you are on the North Shore of Chicago someplace, in a high-rise apartment with plenty of bucks, and you go to the hospital to get treated, you are going to get better and more thorough treatment that someone who walks in off the street and gets referred over to Cook County because of insufficient money to meet the $50 minimum, or whatever it is. The answer is "No," and we know that.

Ms. Butler, you talked about nine States trying to pick up this thing some way and expanding their own Medicaid programs over the last year. What are those nine States, and why have they picked it up and other States have not?

Ms. BUTLER. Well, interestingly enough, most of those States—Florida, Georgia, Illinois, Iowa, Mississippi, Oregon, South Carolina, Virginia, and Texas and that is over the last 3 years many of them very recently—tend to be southern. One reason I think the Southern States have looked hard at Medicaid as a financing option is that they get a higher proportion of the costs paid by the Federal Government, up to 78 percent, whereas some of the more wealthy States and those in the North and the West, can share in some cases only 50 percent of their costs. So I think it is more attractive to some States than others.

Senator GLENN. What I was getting at is this: Is it within the capability of every State to pick up the same way those 9 or 10 States have done?

Ms. BUTLER. Well, I think some States argue that their budgets are tight. For instance, in Colorado, I have been attempting to get our legislature to expand Medicaid to cover some of the uninsured. They are resisting that, partly because they do not like the Federal Medicaid Program in general, and partly because the existing program that they have for the poor, which basically finances some private hospitals uncompensated care, costs them less than adding a lot of the Medicaid groups would do.

So, I think it is less attractive in some States.

Senator GLENN. I think we have a big difference among the States in the ability to pick up this load. I think one of the basic concerns to me at least, is that some States cannot do this, while other States can. And to me, this thing of just cutting back on the Federal aid—we have nearly a $1 trillion budget in this country now, and yet the administration has been hot after cutting $1.2 billion out of Medicaid of all things.

I just have difficulty accepting that. I worked to get that restored on the floor, and we lost; we did not have the votes. I voted for it, and we did not have the votes to put it through—$1.2 billion for Medicaid to help those who need it the most in our society. To me, that is just unconscionable that we would try and dump people for $1.2 billion. A billion is a lot of money. I do not mean to deprecate and say it is a tiny amount. It is not. But our basic problem is who needs help the most in this country. It is those who have a problem like this, not of their own making, and they are indigent. They cannot hack it, they cannot cope with the problem, and we say, "Tough. That's it." Macho—a big John Wayne image we have got to project around here. Every State has got to be on its own, it has got to stand on its own here. We have so much lack of compassion among some of the people here. I just cannot imagine doing that.

There is another question here, too. The Congress instructed the Department of Health and Human Services, HHS—"Health and Human Services", what a grand title, "Health and Human Services"—to make appropriate adjustments in Medicare payment rates for hospitals serving large numbers of low-income beneficiaries, trying to help out in this area. And what has happened? They have ignored us. We cannot follow up.

Ms. BUTLER. The courts have now stepped in.

Senator GLENN. Yes; the courts are stepping in. We finally had to take our own Government to court to get them to do what Congress said because we had a concern for some of these people that cannot make it on their own. What in heaven's name is going on when we are trying to make economies on the backs of human beings who cannot even get into a hospital? For heaven's sake, to get a little bit of help from their own Government—just minimal—we are not talking about quality health care; we are talking about any health care for some of these folks.

And we had to take HHS to court to get them to do what Congress wanted them to do. So I think we ought to have had a couple of administration witnesses up here today, to find out why we had to take our own administration to court to get them to do what Congress wanted them to do for a comparatively small, tiny amount of money compared to the overall Federal budget.

Mr. Manning, I think your testimony covers this to some extent, but what effect would this have on Cuyahoga County, for instance?

Mr. MANNING. Yes, Senator Glenn. Implementing the disproportionate share adjustment could be exceedingly helpful, particularly in a hospital such as ours, because we do have such a high proportion of indigent patients. As we lose capacity from private sector financing, if we could get something done on the disproportionate share issue, I think it would be a tremendous help not only for the Cuyahoga County hospital system, but for all the other inner-city hospitals,

Senator GLENN. How much would the $1.2 billion cut that was made in Medicaid, which is supposed to help those who really need some help, impact on you? How many million dollars?

Mr. MANNING. We have done a pro forma of our hospital's budget for 1986 and found that the combination of changes in Medicare reimbursement and Medicaid are going to leave us in the Cuyahoga County hospital system with a deficit of $7,513,000, even after an appropriation from the county of $24,500,000. So we have a very serious budget problem that we are looking at for the hospital for next year, most of it caused by downward adjustments in the Medicare and Medicaid financing.

Senator GLENN. You indicate in your testimony, I believe at page 8, which I was looking at here in your longer statement, that while your ability to provide medical care to the poor has grown steadily in its capacity, the outlook today is that your capacity in 1986 and thereafter will rapidly deteriorate, no matter what you do, I gather. Is that right?

Mr. MANNING. Given the direction of current circumstances; yes, sir.

Senator GLENN. The county commissioners in Cuyahoga County formed a task force to look into this and what is going to happen in your county hospital system, I believe. When are they to make their report, when will they get that in, and do you have any advance information on what their recommendations will be, other than just saying that the Federal Government should provide money. I know that is what many local groups do, and I am not saying that that is what they are going to do. But do they have any new ways of coping with this?

Mr. MANNING. I appreciate your raising that, Senator. The task force grew out of a proposal from the management of my hospital from me, for a restructuring of the Cuyahoga County hospital system into a charitable corporation, because we are finding ourselves more at risk as a public hospital than we would be if we were operating in the private sector.

Obviously, the presence of that hospital and its public nature is very dear to the citizens of Cuyahoga County. No change is going to happen without a great deal of exploration by the county government. The task force was therefore appointed. There was a request from the president of the county commission, Tim Hagan, that the task force move swiftly, hopefully, within a period of 6 months, and report back. Since the task force was formed—and I serve on it—there has been a request from the task force itself and its chairman for more time.

Senator GLENN. I would be very interested in having a copy of that at the earliest time so I could submit it to the committee, or you can submit it directly to the committee—or submit it both directions, to the committee and to me, when that gets in. I think how we are able to cope with these problems in an old industrial center that is modernizing, like the Cleveland and northeastern Ohio area, may be able to set the tone or set the direction of how we cope with this in other places. If we can cope with it there, where there has been a reduced taxation base and so on through the past several years, and back, we hope, as I mentioned earlier, but if we can cope with it there, maybe we can cope with it other places around the country. States of the South and West that are expanding have a far greater capability than we do in some of the older industrial States to cope with a problem like this.

So I would appreciate your giving us a copy of that at the earliest opportunity.

Mr. MANNING. We certainly will be happy to provide the committee with the results of the task force's work.

Senator GLENN. This competitive bidding thing that you got into, too, that is another one that is going to cut back into our ability to take care of the poorest of the poor, also. It means you are going to have less pay left to take care of indigent patients on a charity basis; is that correct?

Mr. MANNING. Yes, sir; as a result of the marketplace dynamics described by Professor Reinhardt in his testimony. We have an oversupply of beds in Cleveland and an oversupply of physicians. The oversupply has made it possible for Blue Cross to come forth with its required price-bidding system which is tending to cause hospitals, out of desperation, to bid prices lower than would permit them to carry the costs of some of the indigent services.

Senator GLENN. The payment under DRG's, when that is fully in effect, is that going to affect you further on this?

Mr. MANNING. Because we are a teaching hospital and a large urban hospital, each year of transitioning has a direct financial impact on our institution. Essentially what is happening is that more of the Medicare money is flowing from the larger innercity hospitals in Northeast industrial areas to the Sun Belt, the smaller hospitals, and so forth.

Senator GLENN. Dr. Schiff, how is Cook County paying for this? You have got a lot of people, you have had a big increase in patients referred over to Cook. How are they taking care of it?

Dr. SCHIFF. Well, a combination of things. The number that the Medicaid cuts translates into in terms of policy applications in Illinois, we are going to be seeing a $17 million cut in our budget for this fiscal year.

Senator GLENN. Are you going to pick that up with local taxes? Has that been proposed?

Dr. SCHIFF. The deficit is assumed by the county, so they will be stuck doing that.

Senator GLENN. Are they going to cut services or up the budget?

Dr. SCHIFF. Well, it probably looks like it will be combination of both. I really am not sure what—and I do not speak for the hospital. But it is apparent to me that something has got to give. Services will have to be cut, and we will have to make do with less money, unless the taxpayers cough up additional property taxes to pick up this deficit.

Senator GLENN. Mr. Manning, are you going to have to cut services in Cleveland?

Mr. MANNING. I think, we have to look forward to that possibility. I think there are a number of things to worry about here. I think first—

Senator GLENN. Is there a sufficient tax base there that we can raise that can keep the services to this neediest of the needy?

Mr. MANNING. In Cuyahoga County, no, sir; I do not believe that you can look to local taxes to sustain our institution as we lose financing from these other sources.

Chairman HEINZ. Senator Glenn, Professor Reinhardt is going to have to leave in the next 5 or 10 minutes, and I have one question I would like to ask him, but if you have any questions you would like to ask him——

Senator GLENN. I have just finished, anyway, and I have another committee I have to go to right away. But just let me say what I have said before. I think that to try and cut back at the Federal level on this is wrong. It is a national problem—everybody here, there is not a single person who did not say something about it being a big problem that goes just beyond your local area—it is a national problem, and I think we should face this together. And I am not a bleeding heart liberal Democrat that says we ought to have a big Federal program for everything that comes down the road. I know we have to make some cuts in different places. But we have sure got a lot of places we should cut before we take the poorest of our poor, people who are in a democracy. They are every bit as important people as anyone in this room, or the President, sitting down the street in the White House. They are Americans. And there is some basic level beyond which we do not let Americans sink. If that means we share that burden together, then we share that burden together. And to me, we are falling below that level when we cut out this aid for the poorest of the poor, without even giving a time period for States or local communities to pick that up. It means people are going to get dumped and die. In this country, the fount of medical knowledge for the whole world, we have

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got people dying because we are going to cut back—I think that is unconscionable.

Thank you, gentlemen. I appreciate all of your testimony today, and I am sorry I have to leave.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Glenn, thank you very much.

Professor Reinhardt, what we have been hearing from Senator Glenn and Dr. Schiff is really the following—our urban areas such as Cook County, Cuyahoga County, Allegheny County in my home area, and many others, have accumulated for a lot of reasons a disproportionate number of poor people and elderly. In addition to that distribution of people which has only an accidental correlation with resources, tax base, and other ability-to-pay measures, what we are finding is that the relatively better-to-do health care providers—the hospitals that are private, or maybe "boutique" nonprofit—are dumping their patients onto taxpayer-supported institutions. So what has been described is that in addition to the burdens traditionally assumed by local and, to a certain extent, State jurisdictions, the burden for the poor is being dumped onto local jurisdictions. Sometimes they get some help from the States, sometimes they do not.

Is the responsibility for dealing with this, should it be philosophically, just something that the local jurisdictions should deal with? It is something that local jurisdictions and the States should deal with? Or, is it something that is a shared responsibility? Or, is it something that the Federal Government by itself should deal with? What is the right philosophical answer to that question, and why? And then, if you have got a philosophical framework, where do we go from there; what does it mean in terms of programs?

Dr. REINHARDT. That is an interesting question. Philosophically, you are asking about our conception of nationhood. I happen to have the misfortune or fortune of having been apprenticed into social ethics in three countries—West Germany, Canada, and the United States—so I have some experience in these matters. In the former two countries, it would certainly be viewed a Federal matter, because someone in Hamburg would certainly be concerned about the welfare of a German child in Munich. The same would be true in Canada. Someone in Ontario would certainly be concerned over the health care of a Canadian baby in, say, Manitoba.

I am puzzled by the proposition that assuring health care for the poorest Americans is a State and local matter. I believe it to be a Federal matter. Because if you put the question another way, you could ask me: Should I in New Jersey be concerned about what happens to, say, an American infant or aged in Pennsylvania, and vice versa?

If the answer is yes, I should, because we are one nation, then clearly I have to talk about a Federal program, because the only way a New Jerseyite can affect a Pennsylvania person is through the Federal Government.

If you tell me it is a State and local matter, you are really telling me no, it is none of my business what Pennsylvanians do with one another—what happens to American infants in Pennsylvania. But I would argue that is a very peculiar conception of nationhood, nor is it one that I think people really share if it were put to them that

way. I would hope that, when we worry about somebody, an American hostage in Iran, or in Paris—that this concern is a pro-American sentiment, and not just an anti-Iranian or anti-French sentiment. And in the same vein, it seems to me I should worry about every fellow American's health status, particularly when they are sick. And sickness strikes not so much as a deserts, but as pure misfortune. Some wag recently suggested to me that the best way to get good health care for America's poor would be to put them all on planes and have the latter hijacked. I do sincerely hope that that is just a joke.

Chairman HEINZ. As you are well aware, though, the legal structure, the regulatory structure, the insurance structure of the health industry, with the exception of Medicare, the one true Federal health care program, is State oriented.

Dr. REINHARDT. Yes. And we are not unique in that way. Many nations, Canada and West Germany both, implement much of their Federal policy through State and local administrative agencies, or share the financing among levels of government. For example, Canada is 50-50; the Federal Government sets guidelines for the minimum which must be offered, which is quite generous, and simply bribes the Provinces into accepting—they could not possibly refuse the deal, because the Federal Government picks up half. The point is that there are powerful national guidelines on the floor beneath which a fellow national should not sink.

Chairman HEINZ. How is that really different from Medicaid?

Dr. REINHARDT. Well, Medicaid is some such device, but the eligibility standards are rather vague and so is coverage. The Canadian program differs from the Medicaid one primarily in the sense that the standards are national, fairly rigid, and extraordinarily high. The Medicaid Program could of course, be altered to be a more truly national program, but we are then talking about additional Federal moneys.

Are there any misspent Federal funds that could be redirected in this way? Sure. I would take these funds from people like me. For example, I get dental care at 50-cent dollars courtesy of the Federal tax laws. A lot of Americans get a lot of fringe benefits of 50-cent dollars. I think it is wholly unjust that I should get dental care at half price, my secretary at 75-cent dollars, and some at 100-cent dollars. Our insurance industry thinks that it is just great to exempt employer-paid health and dental insurance from Federal taxes; but that industry's motives are quite simple and quite transparent. They make money by redistributing economic privilege upwards.

Chairman HEINZ. Well, one of the things you advocated in your testimony was to have the Federal Government become the health insurance of last resort for at least catastrophic care.

Would it make sense, following the 50-50 model, that maybe it should be really a Federal-State program of last resort, rather than strictly a Federal program of last resort?

Dr. REINHARDT. Yes. The details could be that the Federal Government provides the mandated catastrophic package, leaving it to the State and local governments to top that off to various degrees of generosity, as local preferences dictate.

That is something where one would have to work out the details, but in principle, it could be done.

Incidentally, let me clarify what I mean by "mandating" health insurance. It should be mandatory that people have insurance, but that is not the same as saying that business firms should be mandated to pay for it.

The problem with mandating health insurance to employers, particularly to small business firms, is that this will be a blow to entrepreneurship, and entrepreneurship is what we would like to encourage. It would be better to be honest about it—a tax is a tax, no matter how you slice it. If we mandate small private business to pay for health insurance, you essentially have imposed a payroll tax on them. It is just a tax going by another name.

It might be better, if we care about entrepreneurship, to address the American people directly and say to them: "We have a certain number of tasks to do—defense, care of the aged, education and health care of the poor, and so on—and that takes money. What we are taking from you in the form of taxes does not cover the bill and we need to raise taxes." At some point in the near future, some American politician will have the courage to say that. There is no other way, as is obvious by now.

I would be happy to pay more taxes and I think actually, for health care, many Americans would be willing to pay more taxes. Survey after survey has shown that.

Chairman HEINZ. Thank you, Professor Reinhardt.

I want to note the presence of Senator Nickles. Senator Nickles, do you have any comments or questions.

For Professor Reinhardt's benefit, it is 11:30 by that clock, and we do not want you to miss your plane. We thank you for staying as long as you have.

Dr. REINHARDT. I have to produce some GNP in New York today.

Senator NICKLES. I will withhold questions, Mr. Chairman. Thank you very much. It is an interesting hearing. I apologize to our panelists, particularly the first panel, as well, that I was not able to make it.

It is an interesting dilemma that we face, and I appreciate the comments that were made by the panelists and I look forward to working with the chairman and others to see what kind of solutions we might be able to come up with.

Chairman HEINZ. I think we have gone over the ground pretty well. I guess I just want to return to Professor Reinhardt's comments and say that I think he has made a very strong case when he says that we are rationing health care in the midst of plenty—a surplus of beds, a surplus of doctors, a surplus of money going into health care, according to most health care experts that we have heard—and yet, we have literally millions of people who are not getting any health care at all, who have no coverage, who are being either "dumped"—or who disappear after being turned away and we do not know what happens to them. I think that the dilemma that has been referred to is not an economic dilemma, you are quite right; it is a moral dilemma.

We understand that some of the choices we have made in trying to give everything to everybody, to be egalitarian and say everybody is entitled to exactly the same kind of medical care, and freedom of choice, if you will, and the freedom from regulation or the libertarianism that providers have enjoyed—unless they are county-paid providers—that these choices are fundamentally in conflict unless you want to pay an astronomical price to tug those resources back to treat, if you will, the least fortunate, the poorest, sometimes even the most difficult patients. We have not faced up to that, yet we are paying probably as large a price as if we had. It does not make any sense.

The question I suppose we are going to face as Members of Congress is how do we find a way to reallocate those resources that does the least damage to our principles which we want to hold onto as best we can, recognizing that we cannot be pure anymore, unless we want to continue to pay an unaffordable price, just keeping the system on those two opposed principles.

Professor Reinhardt, I think you have done an extraordinarily good job of framing the debate for us.

Dr. REINHARDT. Thank you. Thank you for having me, and thank you for letting me go.

Chairman HEINZ. Thank you.

I want to thank our witnesses. If you have any closing thoughts or comments, I would be happy to have them.

Dr. Schiff?

Dr. SCHIFF. I think I would just like to, in affirmation of or emphasizing the point you were making, assert that I think that the biggest bang for the buck, to use the expression, really does come from giving health resources to the uninsured, underserved population. I think the marginal benefit of giving additional resources to people who have received a lot of medical care—the analogy I use is someone with their 18th round of chemotherapy, who has not responded, as much as that is somebody I care very much about, no one denies that that person should continue to have access to health care. However, I think that for the kind of persons that we are seeing, our ability to influence their outcome is very much greater. If we are really looking at the cost-effectiveness of various interventions, I think the Government will find that it will get a lot for its money by addressing some of these unmet health needs. These are people who really do not receive any health care at all.

The last concept I would like to introduce, which has really been alluded to here—there is something analogous to the discouraged worker phenomenon where people drop out of the unemployment statistics, sort of give up. I was being asked what is happening, and are we getting a two-tiered system. I think we are getting a group of people who I would call the discouraged sick who, after realizing that their access is severely limited in these various settings, and do not feel like waiting the 6–8 hours that, the walk-ins at county emergency room often wait, they just stay home and forget it. Many of them, of course, will get better on their own. They have self-limited illnesses. Many will get worse. The growing numbers of discouraged sick is another phenomenon that, again, is an invisible

and unmeasured one, but I think has to be recognized and addressed.

Chairman HEINZ. I would like to note the presence of Senator John Warner. Senator Warner represents the Commonwealth of Virginia. There are not that many Commonwealths around. Pennsylvania is another one, and Massachusetts is a third.

Senator Warner, Professor Reinhardt of Princeton had to leave to catch a plane——

Senator WARNER. I met him in the hall as he was departing.

Mr. Chairman, I commend you for bringing this hearing, because it does point up that special category, and we must see where we can help.

Chairman HEINZ. If there are no further comments, I want to thank our witnesses and thank all the people who made this a truly excellent hearing. It is my hope that we in the Congress, the Senate, will take the excellent advice that we have gotten to heart, and that maybe we will actually be able to do something about it. As I noted earlier, I have introduced legislation, the Health Insurance Availability Act, that is a very small step forward, but it is a step, and it is my hope that we can use that as a means of focusing not only on that particular problem of people who have an illness or have a medical condition that prevents them from getting health insurance, to focus not only on that, but on the larger related issues that we have touched upon today.

I thank you all, and if there are no further comments or questions, the hearing is adjourned.

[Whereupon, at 11:40 a.m., the committee was adjourned.]

APPENDIX

Material Related to Hearing

ITEM 1

Background Paper
Prepared by the Staff of the
Senate Special Committee on Aging

"AMERICANS AT RISK:
THE CASE OF THE MEDICALLY UNINSURED"

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EXECUTIVE SUMMARY

The swelling ranks of Americans without health care insurance is a major failing in the Nation's health care system. Today, 35 million citizens without insurance suffer unnecessary pain, disability, and even death.

THE NUMBER OF AMERICANS WITHOUT HEALTH INSURANCE IS INCREASING

1 in 6 Americans were uninsured in 1983. Of these, almost 3 million were age 55 to 64. Almost 400,000 persons over age 65 have no insurance of any kind, including Medicare and Medicaid.

Since 1979, there has been a 20 percent increase in the number of Americans under age 65 who lack health insurance.

UNINSURED OLDER AMERICANS, AGED 55-64, ARE A PARTICULARLY HIGH RISK GROUP

1 out of 5 early retirees age 50 to 54 are uninsured. Persons age 55 to 64 are also at the greatest risk of any age group of having inadequate coverage.

Persons in this age range have high requirements for health services, with rates of chronic illness 2 to 4 times higher than younger individuals; they are as much as 4 times more likely to be hospitalized.

Once unemployed, this group remains out of work longer than younger workers, increasing the risk of no health coverage.

THE UNINSURED REPRESENT A BROAD CROSS SECTION OF EMPLOYMENT STATUS

Among the unemployed, 21 percent of those age 55 to 64, or members of their families, have no health insurance. These individuals: are too young for Medicare; do not qualify for Medicaid on the basis of income but are still too poor, or too sick to obtain private insurance.

19 percent of all pre-retired (55-64) part-time workers are uninsured. Either they work for an employer without a company plan or cannot afford to participate in a plan.

Of the pre-retired uninsured, 28 percent are full-time workers.

LACK OF INSURANCE IS NOT A FACTOR OF INCOME ALONE

Persons with low incomes traditionally have been handicapped in their access to health insurance. 36 percent of poor persons age 55 to 64 are uninsured today.

Over half (53 percent) of all pre-retired persons without insurance at income levels of middle class or above. Today, over 1.5 million Americans aged 55 to 64 with incomes above 150 percent of the poverty level lack any health insurance coverage.

According to the American Association of Retired Persons, an individual comprehensive health policy for one person would cost $3400 per year in 1984.

WIDOWS AND DIVORCED WOMEN AGE 55-64 HAVE A 1 IN 5 CHANCE OF BEING UNINSURED

Also, of women in this age group who have never married, 1 in 6 are uninsured.

PERSONS WITH A PRE-EXISTING ILLNESS ARE OFTEN UNABLE TO GET INSURANCE AT ANY COST

Statistics are not available on the number of Americans presently uninsurable for health reasons. Given recent advances in medical technology that increase the number who survive cancers and chronic diseases, there should be a considerable increase in this category of uninsured, however.

TRADITIONAL SOURCES OF GOVERNMENT-SPONSORED HEALTH COVERAGE HAVE BEEN SHRINKING

Only 46 percent of all Americans living near or below poverty are covered by Medicaid, down from 63 percent in 1975. Between 1982 and 1985, total federal funding of Medicaid decreased by $4 billion, with further reductions proposed for the future.

THOSE WITHOUT INSURANCE OR THE DOLLARS TO PAY FOR CARE DEPEND ON HOSPITALS WILLING TO PROVIDE CARE FOR FREE

With increasing pressures of competition and cost control, many hospitals have severely limited the amount of charity care they provide. More and more frequently, uninsured individuals are being denied admittance to hospital emergency rooms, asked to put down a large deposit before care is provided, or "dumped" from hospital to hospital until charity care will be offered.

The burden of caring for the uninsured falls most heavily on public hospitals. Chicago's Cook County General Hospital reported a 5-fold increase in private hospital patient transfers to the facility during 1982-83; a Los Angeles hospital reported patient transfers doubled between 1981-84.

AMERICANS AT RISK: THE CASE OF THE MEDICALLY UNINSURED
SUMMARY OF FINDINGS

I. INTRODUCTION

Health insurance provides the ticket into the doors of the country's hospitals, clinics and doctor's offices. Traditionally, the public-private patchwork of health insurance coverage has afforded basic protection to the majority of Americans. However, today there are 35 million Americans who find themselves without health insurance. 5.5 million of these are age 45 to 54 and 2.9 million are age 55 to 64. Surprisingly, even 389,000 persons over the age of 65 are without insurance of any kind even though the common perception is that the elderly are taken care of by Medicare and Medicaid.

The number and proportion of the uninsured is increasing substantially. The number of uninsured non-aged persons, the only group for which trend data is currently available, increased by 20.4 percent from 1979 to 1983.

Traditionally, the public-private patchwork of health insurance coverage has afforded basic protection to the majority of Americans. Prior to the last recession , the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time or low-skilled jobs, in which employers generally did not provide health insurance coverage. Most working Americans received health insurance through their or their spouse's employer. Others were protected by public insurance programs or their costs were picked up by health care providers who subsidized non-paying patients by shifting these "bad debts" to other payers.

But in the wake of the last recession - 10.7 million Americans lost their admission tickets to the health care delivery system (CBO). These people lost health insurance protection when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Indeed, to examine the situation of the uninsured today reveals a problem which is deep-seated and widespread. Cutbacks in Medicaid, and other public programs are causing cracks in those sources of health care which directly serve America's uninsured. In addition, the changing nature of America's health care, with its reforms in reimbursement, heightened competition, and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured patient to obtain even emergency access to health care.

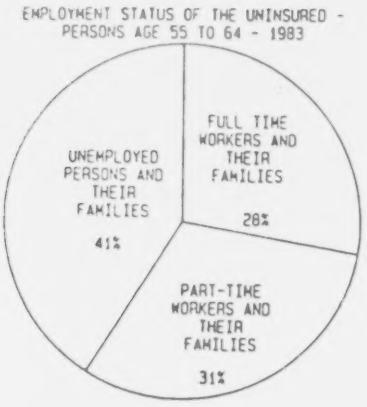
* Unless otherwise noted, current statistics on the uninsured are from the 1984 Current Population Survey and are for 1983. Tabulations by Tom Gabe of the Congressional Research Service.

*The Committee would like to thank Deborah Chollet, Ph.D. of the Employee Benefit Research Institute and Katherine Swartz of the Urban Institute for their assistance.

II. Who are the uninsured?

Persons who are medically uninsured do not have health insurance and are not or would not be able to pay for extensive health care costs should the need arise. The medically uninsured are a very diverse population. Surprisingly, they are not necessarily poor or unemployed.

Today the uninsured include individuals in three employment categories - the unemployed, part-time workers and full time workers and their families. As the chart below shows the near-elderly uninsured are about evenly divided between these three groups.


EMPLOYMENT STATUS OF THE UNINSURED -
PERSONS AGE 55 TO 64 - 1983
FULL TIME WORKERS AND THEIR FAMILIES
28%
PART-TIME WORKERS AND THEIR FAMILIES
31%
UNEMPLOYED PERSONS AND THEIR FAMILIES
41%

Full time workers and their families include workers or members of families in which the head or spouse of the head is a full-time worker.

Part-time workers and their families include workers or members of families in which either the head or spouse of the worked but neither worked full time.

Unemployed persons and their families include unemployed persons or members of families in which the head and spouse of the head are unemployed.

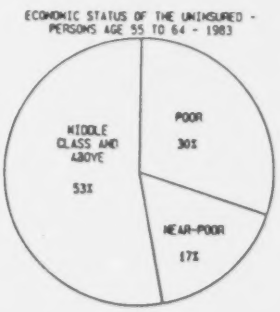
Source: 1986 Current Population Survey

o The unemployed and their families who do not qualify for Medicaid or other categorical health insurance programs, who can not afford health insurance and who could not afford to pay for the costs of health care should the need arise. This group includes early retirees and disabled persons who are waiting to become eligible for Medicare coverage. Twenty-one percent of all near-elderly (age 55 to 64) unemployed persons and their families are without the protection of health insurance. This group makes up 41 percent of all uninsured near-elderly persons.

o Part-time workers whose employer does not offer a plan or who can not afford to participate in a plan. This group includes but is not limited to the part-time employed, short-term employed, non-resident aliens and migrant and seasonally employed persons. Nineteen percent of all near-elderly part-time workers and their families are uninsured. This group makes up 31 percent of all uninsured near-elderly persons.

o Full time workers who are uninsured because they can not afford to participate in employer plans, or whose employer does not offer a plan or who elects not to participate in a plan. Seven percent of all near-elderly full time workers and their families are uninsured. This group makes up 28 percent of all uninsured, near-elderly persons.

The uninsured also include both the poor and people who are relatively well off. As the chart below shows the near-elderly uninsured are about evenly divided between the poor or near poor and people with middle-class incomes or higher. They are:



Poor = 100% of poverty
Near-poor = between 100 and 150% of poverty
Middle class and above = above 150% of poverty

Source: 1984 Current Population Survey

o Poor persons who can not afford private or employee sponsored health insurance and who are not eligible for categorical programs. Traditionally, persons with low incomes have been handicapped in their acess to health insurance. Today, over one-third, 36 percent, of poor persons age 55 to 64 are uninsured and they make up 30 percent of the pre-elderly uninsured.

o Persons who are not low income but who can not afford health insurance. While being poor greatly increases the likelihood of being uninsured, surprisingly large numbers of non-poor persons are not insured. Over half, 53 percent, of all uninsured near-elderly persons have incomes that are middle class or higher. Today, over 1.5 million near-elderly persons with incomes above 150 percent of the poverty level are uninsured.

Two other categories of the uninsured are increasing in prevalence:

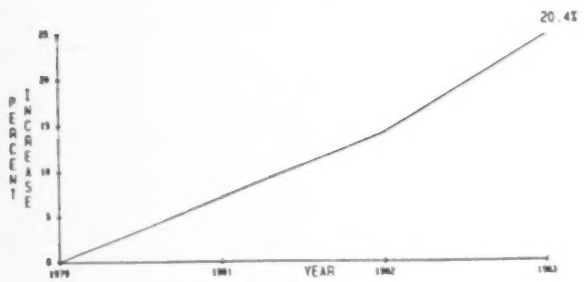
o Widowed or divorced persons and their families whose change in marital status causes them to lose their insurance. Today 1 out of 5 widowed, divorced or separated women age 55 to 64 are uninsured. Women this age who have never married are also disadvantaged in their access to medical coverage. 1 out of 6 of this group are uninsured.

o Persons who because of some pre-existing illness or impairment are considered by insurers to be too risky to insure. These people are not necessarily poor, but the continued threat of high medical costs increases the likelihood that they will become indigent. Uninsurables include people with both chronic and acute health problems. Statistics are not available on how many people are presently uninsurable for health reasons. However, with advances in medical technology that have increased the number of people who are surviving various cancers and chronic diseases and improved diagnostic tests that make it easier to identify diseases at early stages, the number is considered by many to be increasing substantially.

III. MAJOR TRENDS IN THE UNINSURED

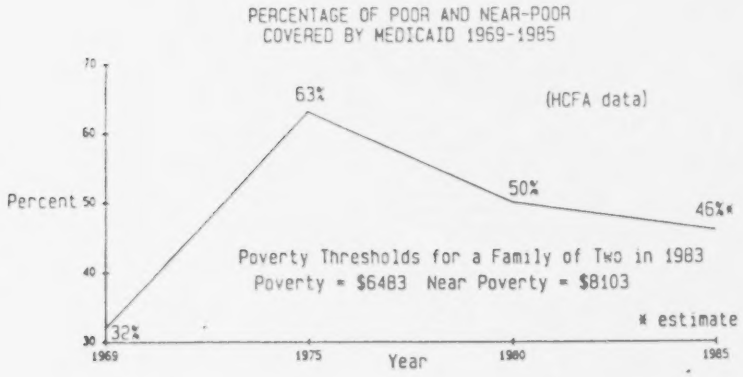
The number of uninsured non-aged persons, the only group for which trend data is currently available, increased by 20.4 percent from 1979 to 1983. The Urban Institute attributes this difference to the last recession and the fact that many uninsured adults now work for small firms that pay low wages and do not offer health insurance as a benefit. According to the Congressional Budget Office, 10.7 million persons lacked health insurance coverage due to a job loss right after the peak of the recession in December 1982.

CUMULATIVE PERCENT INCREASE IN THE NON-AGED UNINSURED POPULATION



Source: Current Population Survey for indicated years

While the need for health insurance has been growing, the traditional sources of government-sponsored health coverage - primarily Medicaid and other categorical programs - have been shrinking. Currently, only 46 percent of all Americans living in poverty, or near poverty, qualify for Medicaid (see chart). This amounts to a substantial deterioration in Medicaid coverage of the poor since 1975, when 63 percent of those living in poverty, or near poverty qualified for Medicaid. Between fiscal years 1982 and 1985, total federal funding of Medicaid decreased by $4 billion, and further reductions have been proposed for the future.



Lack of health insurance can no longer be viewed as just a problem for the unemployed. Fifty-three percent of all uninsured near-elderly persons have incomes above 150 percent of poverty and 28 percent are employed in full time jobs or are members of families whose head is in a full-time job. With escalating medical care inflation, the cost of health care is too high for the poor or those with moderate incomes.

Increasingly there will be problems with employee health insurance as employers cut back on employee benefits and seek to convert to self-insured status.

Most uninsured persons who can not afford health care end up at the door of community health clinics and hospital emergency rooms. The sources of funds for these services are drying up. Historically, hospitals have financed uncompensated care by shifting costs to public and private third party insurers. The most important factor in the declining ability of hospitals to cost-shift is the changing nature of Medicare reimbursement. Whereas hospitals used to be reimbursed by Medicare for basically whatever they charged, this is no longer true under the new prospective payment system (DRG's). At the same time, the ability to charge uninsured and self-paying patients higher rates in attempts to make up a deficit are also drying up. In addition, for the public hospitals a traditional source of financing has been local tax revenues. This factor is placing strain on local revenues.

IV. WHY LACK OF INSURANCE IS A PROBLEM FOR THE NEAR-ELDERLY

The problem that the lack of health insurance represents for persons age 55 to 64 has been largely ignored by policy makers. In 1983, there were 2.9 million uninsured persons age 55 to 64. Recent tabulations of the 1984 Current Population Survey by the Employee Benefit Retirement Institute demonstrate the severity of the problem for this group. For persons age 50 to 54 who reported that they had retired, almost 1 out of 5, 19.2 precent, reported that they did not have health insurance. Close to 18 percent of those age 55 to 61 were uninsured. In addition , the National Medical Care Expenditures Survey (NMCES) conducted in 1977 and 1978 found that persons age 55 to 64 are at the greatest risk of inadequate coverage.

The near-elderly and older adults have high requirements for health services. Persons who are age 45 to 64 have rates of chronic illness and days of care in the hospital as high as 4 times those for persons age 17 to 44. Rates for length of stay in hospitals are 2.5 to 3.6 days longer for this group than for persons age 17 to 44. The near-elderly also visit physicians at an average of 5.1 times a year, compared to 4.4 visits per year for persons age 25 to 44. While rates for acute illnesses are lower for this age group than for younger persons, they are 16 percent higher than the aged population.

Long term unemployment makes the cost of insurance premiums for this age group prohibitive. The near-elderly are disadvantaged in the labor market if they loose a job. Numerous studies have shown that once older workers loose their jobs, they stay unemployed longer than younger persons, suffer a greater earnings loss in a subsequent job than younger workers and are more likely to give up looking for another job after a lay-off. Persons age 55 to 64 are particularly vulnerable during times of high unemployment. For instance, in 1983, 19 percent of all unrelated individuals age 45 to 54 were unemployed for the entire year, but this figure was an astounding 40 percent for persons age 55 to 64.

V. THE RISING NUMBER OF UNINSURED

The number of Americans lacking health insurance has been growing due to a variety of factors, including increases in the rates of unemployment and poverty. As mentioned earlier, while the need for insurance has expanded, the traditional sources of government-sponsored health coverage -- primarily Medicaid and other categorical programs -- have been shrinking. Medicaid is very restrictive, with eligibility generally limited to the very low income aged and disabled, and single-parent familes. As mentioned earlier, currently only 46 percent of all Americans living in poverty qualify for Medicaid. This amounts to a substantial deterioration in Medicaid coverage of the poor since 1975, when 63 percent of those living in poverty qualified for Medicaid.

In recent years, Medicaid has been cut back at both the Federal and State levels. Between fiscal years 1982 and 1985, total federal funding of Medicaid decreased by $4 billion, and further reductions have been proposed for the future. The States, which jointly finance the Medicaid program with the Federal government, cut spending as well, particularly by eliminating eligibility for optional "medically needy" categories of recipients. Although the recovering economy of the last year has allowed some states to begin increasing Medicaid coverage, it is unlikely that this trend will continue, especially with the threatened additional cuts in the Federal contribution. Overall, Medicaid is helpful to the medically uninsured only in so far as they also qualify for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) cash assistance, or have extremely limited income and assets.

Another factor contributing to the volume of uninsured is the nature of the health insurance market. Individual insurance policies are expensive and often inadequate; they provide minimal coverage for very high premiums, and many policies require healthy examinations. For example, persons with pre-existing conditions such as heart disease or cancer are often unable to buy coverage at any price. The higher incidence of chronic illness among the middle-aged and older population creates enormous problems for this age group when they seek to purchase health insurance.

There are also problems with group health insurance policies. Most participants in group plans have no assurance of being able to continue coverage if they become unemployed or disabled. Moreover, widows and dependent children of deceased employees and divorced spouses and their dependents are usually left without insurance because group plans do not provide for continuity of coverage. Finally, there is a large number of early retirees -- many of whom are forced to leave the labor force because of health problems -- who have difficulty obtaining affordable coverage before they become eligible for Medicare.

Increasingly there will be problems with access to insurance as employers seek to convert to self-insured status. Under current Federal law, there are no requirements that health benefits meet specific, minimum standards. While the Employee Retirement Income Security Act (ERISA) stipulates minimum standards for pension plans, it actually preempts States from regulating employer-sponsored health plans. Thus, by refraining from entering into agreements with insurance companies to provide post-retirement health benefits for employees, employers can avoid the need to design a plan that meets state regulations. Instead, employers are increasingly choosing to

self-insure in order to come under ERISA's scope and to thereby avoid State regulation and State taxation on insurance premiums, and to avoid participating in state catastrophic health insurance pools. In sum, the lack of regulation of the self-insurance market is likely to produce policies that have inadequate benefit packages and inadequate reserves to meet their obligations.

IV. THE BURDEN OF PROVIDING HEALTH CARE TO THE UNINSURED FALLS MOST HEAVILY ON PUBLICLY FINANCED FACILITIES

When an accident or illness strikes, there are few alternatives for persons who lack health insurance, and who also have limited or no financial reserves. Most end up at the doors of community health clinics funded by public funds or private charities or they end up in hospital emergency rooms. In 1984, approximately 3,000 hospitals who received federal funding under the Hill-Burton Act provided an estimated $3 billion of free care to indigent individuals. The Federal government is no longer providing new funds under Hill-Burton. However, hospitals which received these funds under this program have a responsibility to provide free care until their Hill-Burton obligation is fulfilled (usually 20 years from the date of the initial contract).

The Public Health Service also provides limited health services through community health centers, migrant health centers, childhood immunization programs and family planning centers. Other health programs that serve low-income persons include Appalachian health programs, the Indian Health Service, and programs under the Alcohol, Drug Abuse and Mental Health Block Grant, the Preventive Health Services Block Grant and the Refugee Act. The budget cuts of the last few years have eroded the ability of many of these programs to serve their target populations, thus reducing their effectiveness in improving access to care.

The effects of a burgeoning uninsured population have been sorely felt by these providers and are reflected in the sizable jump in their utilization. However, the major burden for providing care to the uninsured and indigent populations falls disproportionately on urban and teaching hospitals. In 1982, forty-two percent of all uncompensated inpatient care (care for which the hospital received no payment) was provided by hospitals in the 100 largest cities, split nearly equally between private and public hospitals. Public hospitals in both metropolitan and nonmetropolitan areas absorb an especially heavy caseload of uninsured persons. While they provide only 20 percent of all hospital care, 40 percent of their care is uncompensated. The National Association of Public Hospitals has reported that free care comprises more than 30 percent of the budget of the average public hospital, as compared to about 3 percent on average for hospitals in the private sector.

Teaching hospitals are also major sources of uncompensated care. In 1982, they provided 36 percent of the $6.2 billion of total uncompensated care although they accounted for only 27 percent of total hospital charges.

VII. THE EFFECTS OF HEALTH COST-CONTAINMENT EFFORTS

Historically, hospitals have financed uncompensated care by shifting costs to public and private third party insurers. This "Robin Hood" approach of paying for uncompensated care is becoming increasingly less viable as the sources of cost-shifting dry up, and the number of hospitals willing to take uninsured patients decreases. While there are a number of factors leading to the declining ability of hospitals to shift costs, perhaps most important is the changing nature of Medicare reimbursement.

Whereas hospitals used to be reimbursed by Medicare for basically whatever they charged, this is no longer true under the new prospective payment system. As the diagnosis related groups, on which the new prospective payment system is based, are fully phased in over the next two years to determine 100 percent of a hospital's Medicare reimbursement, hospital payments will no longer be tied to the individual hospital's costs. Instead, they will be determined on the basis of preestablished national rates for each of 467 diagnoses. This means that, depending on the intensity of services provided by the hospital and other factors such as labor costs, it may be reimbursed for an amount that is less than its actual costs. For some hospitals, especially those providing a large volume of care to severely ill patients or care for which they will not be reimbursed, this increases their need to shift costs to other payers.

At the same time, however, the opportunities to charge insured and self-paying patients higher rates in attempts to make up this deficit are drying up. Insurers, employers and to some extent, individual consumers, are becoming more "prudent buyers," seeking quality care from the lowest cost providers. Thus, the option to shift costs is fast becoming impractical as the emphasis on price competition intensifies.

For the public hospitals, an additional source of financing is local tax revenues. As the number of uninsured cared for by these institutions has increased, so too has the request of these hospitals for additional tax revenues from their communities. To relieve the growing burden on local resources, some states have created "uncompensated care pools." These pools are usually financed either through the state's hospital payment system or through a tax levied on hospital revenue.

VIII. HOSPITALS ARE TIGHTENING UP OR REFUSING TO CARE FOR THE UNINSURED

Hospitals have responded in a number of ways to having disproportionate shares of uninsured patients. Some have begun requiring cash deposits from patients before admitting them to the hospital; others have discontinued those services believed to be most used by indigent, rather than paying patients, such as obstetrics and emergency rooms. Many hospitals have responded to an overload of medically indigent patients by setting explicit limits on the amount of uncompensated care they are willing to provide, including 26 percent of teaching hospitals. These hospitals will refer or transfer indigent patients to public hospitals that are obligated to maintain open door policies.

It is thus not surpising that uninsured individuals are being increasingly denied admission to hospital emergency rooms, asked to put down large deposits before care is provided, or "dumped" from hospital to hospital until they finally find a place where "charity" care is available.

IX. THE PROBLEM OF "DUMPING" -- CASE EXAMPLES

Throughout the country incidents of hospitals "dumping" seriously ill patients on the basis of inability to pay have become more prevalent. While national level data on "dumping" are sketchy, there are data from individual hospitals to give some sense of the "dumping" problem:

o Chicago's Cook County General Hospital reported a five fold increase in private hospital patient transfers to the facility during 1982 and 1983. More recently, Dr. Gordon Schiff of Cook County Hospital has reported that there are 6000 patients taken in ambulances each year from the emergency rooms of Chicago's private hospitals and dumped at Cook County. In addition, "Patients with less life-threatening problems are also presenting in record numbers to the emergency room...having been refused care or having been told that they should go to Cook County for follow-up because of their inability to pay." After doing a survey of 500 emergency room patients, Dr. Schiff estimated that "25,000 patients are being blatantly dumped with another 50,000 visits resulting from shifting of care from community sources to Chicago's only public hospital. These figures do not include the unknown number of people who are referred to Cook County Hospital but fail to comply."

o Harbor-UCLA Medical Center in Los Angeles reported that hospital patient transfers doubled between 1981 and 1984.

o Parkland Hospital in Texas received on average 200 to 250 transfers each month from other hospitals to its emergency room in 1982 and 1983, a major increase from earlier years. Only by implementing major changes in its admission policies and providing new out-patient clinics for non-emergency care did Parkland succeed in reducing the number of dumped patients.

o A study conducted at Highland General Hospital, the major public facility in Alameda County, California, revealed that of the 458 patients transferred from private hospitals to Highland General in one six-month period, 63 percent had no medical insurance. The transfers represented 6.5 percent of all hospital admissions at the hospital. In 33 cases, transfer was judged to have jeopardized the life of the patient. Not one of these 33 patients was privately insured.

o The National Association of Public Hospitals recently surveyed its membership on the subject of transfers. The preliminary analysis shows that of the 570 transfers reported by 16 of its 50 members over a two week period, one fourth of all transferred patients were "self-pay" patients which usually means uninsured. Every one of the transferred patients required emergency room or inpatient care. One fourth of the transfers were also inappropriate, that is, the people were sent by other hospitals without any medical assistance or paperwork. 32 percent of the transfers were over the age of 45.

Another indication of the growing dumping problem is the increasing number of stories appearing in the press. For instance, the Wall Street Journal recently reported the case of a Rumanian refuge who was hit by a car, received critical head injuries, and was denied entrance to two hospitals that had the available neurological care this patient needed. He was refused admission because he had no insurance and could not pay for care.

Instead this victim was forced to stay in another hospital that did not have a neurosurgeon on staff. He subsequently died three days later.

In February of this year, the New England Journal of Medicine published a letter from a physician in North Carolina in which he described two recent instances of hospitals turning away patients needing critical emergency care because they appeared to be without insurance. In both cases, the patients needed the specialized care of teaching hospitals many miles away. In both cases, this physician was queried as to whether the patients had insurance. When he could not offer with certainty a positive response, the hospitals -- hospitals which formerly used to treat large numbers of uninsured patients -- refused admission. In the first instance, the patient was eventually transferred after "much pleading" from the doctor. In the second instance, another hospital was eventually found, but not without a long and critical delay. This physician's letter stimulated a sizable response from the readers of the Journal, many confirming that this doctor's experience was far from unique.

The dumping and transferring of patients are not only inhumane practices; they also increase the health care problems of the uninsured since inadequate emergency care can result in additional expensive and disabling medical problems.

X. WHAT PROTECTIONS EXIST FOR PATIENTS?

Although hospitals are not required to admit every person seeking admission, state and federal statutes and administrative policies now require that they at least provide necessary emergency medical care to any patient presenting in their emergency rooms. Eighteen states have even enacted specific statutes requiring hospitals to provide limited emergency medical services without regard to the patients ability to pay. In spite of these efforts, there are numerous patients turned away from hospital emergency rooms because of variation in standards used by hospitals to identify which patients are in need of emergency treatment.

The definitions given by most statutes, professional organizations and accreditation bodies are broad and, therefore, subject to interpretation by providers. There is little enforcement of the state emergency care statutes; and, in fact, only 7 states provide remedies for violations of them.

The Hill-Burton Community Service regulations apply to all hospitals that received federal assistance under this act. This applies to over half of the hospitals in the U.S. and requires that they provide emergency service to any person who resides in the hospital's service area regardless of his ability to pay for them. There are, however, two problems that have significantly undermined the value of the Hill-Burton requirements. The requirements do not define emergency, thereby leaving it open to hospital interpretation. Second, HHS's Office of Civil Rights (OCR), responsible for enforcing the Hill-Burton community service regulations, has not provided facilities with formal technical assistance on ensuring compliance with their obligations, nor has it implemented a hospital review program to identify hospitals that repeatedly have violated Hill-Burton community service assurances.

Medicaid patients have some protection under the Medicare/Medicaid conditions of participation that require a physician to see all patients who arrive for treatment in the emergency room. Further, the Tax Equity and Fiscal Responsibility Act of 1982 prohibits the imposition of co-payments for a number of services provided to Medicaid recipients, including necessary emergency care provided in hospital emergency rooms.

Hospitals that enjoy the tax-exempt status possible under section 501(c)(3) of the Internal Revenue Code must qualify based on organization and operation for charitable purposes. Provision of emergency services regardless of patient's ability to pay is not the sole basis for determining the hospital's tax status but is an important aspect considered by IRS.

Hospitals also benefit from state and local tax exemptions based on provision of charitable services. There are some instances where this status has been revoked, as in the West Allegheny Hospital v. Board of Property case in Pennsylvania appellate court, in which the hospital lost its tax benefits because it employed a debt collection agency and its billings for patients who received emergency treatment equalled its actual costs.

There have been many court cases resulting from the inappropriate transfer of, or refusal to provide care to, patients presenting in emergency rooms. Generally, courts hold that all hospitals have an obligation to provide at least limited emergency care to all. Nevertheless, the practice of dumping continues, posing a considerable risk to anyone who is not or appears not to be insured.

XI. WHAT CAN AND IS BEING DONE?
STATE LEVEL SOLUTIONS

In the past few years, the States have responded to the problem of financing health care for the uninsured in a wide variety of ways. Many have established special funds for compensating providers, while others have expanded health care programs for the poor and uninsured. According to the National Council of State Legislatures, the following are representative of the options currently available to the States in this area:

Establish a tax on all or some hospitals to develop a revenue pool - All hospitals or selected groups of hospitals (such as those that provide no uncompensated care) could be taxed by collecting a percentage rate of their revenues. This approach is similar to that being used in Florida and New York.

Establish a tax on health insurance premiums - This approach would tax those who purchase health insurance on the basis of a flat percentage of the premium payment. Legislation has been introduced in New Jersey to establish a surcharge on health insurance premiums.

o Develop a tax-deductible trust fund to which people could contribute - States could establish trust funds for indigent care that would be similar to the children's trust funds that exist in a number of states, including Alabama, California, and Illinois.

o Levy a tax on all health services - This option draws on the idea that the burden of financing uncompensated care should be spread evenly among all

health care consumers. It proposes taxing all health care, not just hospitals. As yet, this has not been tried in any state.

o Direct appropriation of state funds - States could appropriate funds directly to the uncompensated care program or in conjunction with another program. This would be feasible for all the states and could take the form of Colorado's line-item appropriation for funding for the state medical indigence program.

o Earmarking state lottery funds - Eighteen states have state lotteries, and a portion of the revenues could be earmarked for uncompensated care. For example, Pennsylvania currently earmarks funds for senior citizens; Michigan, New Hampshire, and Ohio earmark for education; and Colorado earmarks lottery funds for parks and recreation, capital construction, and a conservation trust fund.

o Increasing general sales taxes or special purpose excise taxes on goods, such as alcohol or tobacco - A general sales tax could be increased by a small percentage or a special purpose use tax could be adopted. The idea of targeting "sin" taxes from alcohol and tobacco sales to fund certain health programs has frequently been proposed. Since 1939, Ohio has earmarked highway user tax funds to finance the care of medically indigent accident victims. Oklahoma recently enacted legislation to allow counties to raise taxes to fund indigent care programs.

o Adding an income tax checkoff box to the state income tax form that would allow individuals to contribute to an uncompensated care fund - This mechanism has become increasingly popular, where a checkoff box is provided on a state's income tax form to allow individuals to contribute to a specific cause. Of the 40 states and the District of Columbia that have personal income taxes, 34 have included income tax checkoffs for various purposes. A bill introduced in the Massachusetts legislature would use a tax checkoff to pay for the care of people who are uninsured or experience catastrophic medical expenses.

XII. FEDERAL LEVEL SOLUTIONS

Given the enormous federal deficit and the need to curb spending, it is unlikely that major structural reforms in the health care system will be made any time soon that will greatly expand access to health care for those now finding the doors closed because of their inability to pay. However, there are a variety of initiatives that could be pursued at the federal level that would be fiscally responsible and that would begin to make a substantial improvement in increasing access to health insurance and to health care services.

First, there are a variety of options that could be pursued that would increase the ability of providers to care for the large numbers of uninsured arriving at their doorsteps. In order to compensate the hospitals that provide large portions of free care, it has been proposed that there be included a disproportionate share adjustment in the payments made to hospitals under Medicare's prospective payment system. This proposal has substantial support both within and outside of Congress; the major roadblock has been the Health Care Financing Administration. The advantage of this measure is that it would assist those hospitals that are reeling under the strains of large numbers of Medicaid, Medicare and non-paying patients. The

adjustment could be made so that no new additional costs are imposed on Medicare.

A more ambitious option and one which would tackle the much larger universe of problems created by the large number of uninsured would be for the Federal government to create incentives for states to create all-payer systems. Under these systems, the states would have to include an allowance for charity and bad debt in each payment made to hospitals. Such a proposal is included in the Medicare Incentives Reform Act -- a bill introduced in 1984 by Senator Heinz.

There are also a variety of measures that could be pursued at the Federal level to help increase individuals' access to health insurance protection. For example, the federal government could encourage states and the private sector to expand access to health insurance by making it available and affordable to high-risk persons. It is now easier for an individual with a terrible driving record to obtain automobile insurance at affordable rates than it is for a high risk individual to obtain non-group health insurance. Virtually every state has either an uninsured motorist pool or an assigned risk procedure whereby everyone with a license can obtain auto insurance at an affordable premium, that is, at no more than 150 percent of the average rate. The federal government could require states to make similar arrangements so that individuals who are otherwise unable to obtain health insurance could do so. This option would be especially important to the near elderly who are more likely to fall into the high risk category. Alternatively, the federal government could use its power to tax to encourage private insurers and other insuring entities to participate in risk pools that would offer insurance at reasonable rates to the high risk population.

The federal government could also mandate that health insurance plans satisfy certain minimal requirements in order to retain their tax deductible or tax exempt status. For example, one of the major reasons for loss of health insurance is its failure to continue when an individual becomes unemployed or experiences a change in marital status. No federal statute now assures rights to continue the health insurance policy. This problem could be remedied by requiring that all health insurance must provide that insured persons may continue such policies for a specified time, or even indefinitely, if they pay the full premium themselves. This will assure that such individuals will be more likely to afford private coverage.

The above list does not claim to be an exhaustive survey of potential federal options. It only highlights some of the more obvious measures that could be pursued in this period of fiscal restraint. It should be noted, however, that the most important safeguard against further increases in the number of uninsured is to continue funding Medicaid so that it is at least able to provide current levels of coverage and service. As noted earlier, many states are expanding their role in the provision of funds for indigent or uncompensated care. Built into some of their financing mechanisms is the assumption that Federal Medicaid payments will continue at current levels. In some states, a portion of these revenues may be used to create an uncompensated care pool. Should the Federal Medicaid contribution be reduced, these efforts will be jeopardized.

ITEM 2

Testimonial Letters to the Maryland Legislature in Support of HB 1154, Continuation of Health Insurance

Ladies and Gentlemen of the Economic Matters Committee

My name is Chase Ridgely, Jr. and I live at 721 St. Paul Street, Baltimore, Maryland 21202. Except for three years in the Army, two of which were in the hospital from schrapnel wounds, I have spent most of my life in the insurance industry. I was President of J. Ramsey Berry and Co., Inc., have served on the Board of the Metropolitan Insurance Agents of Baltimore and as a Board Member and President of the National Association of Casualty Agents.

I am appearing here for HB #1154 to amend Article 48A of the Insurance Code, as I have personally experienced the frustration under the current status. I was separated and divorced in 1973. I was covered for health insurance under our company plan. My wife and children were covered under the dependents coverage. When the divorce automatically cut off my spouse, she was left without coverage. Under our legal settlement I agreed to keep her and the children covered. The children remained under the group policy as they were my dependents but my wife was a different situation. Individual coverage now was age-related, restrictive to certain illnesses and less comprehensive than the group.

Now the exposure remained the same as under the group coverage but, the straw that broke this camel's back was that I had to fork out a premium three times my previous expense. But for the fact that we were divorced, I had to bear this unnecesaary additional expense.

If my ex-wife could have remained on the group policy, the insurance company would not have had any additional exposure. The employer would still be guaranteeing the premium and I would still pay the premium by salary deduction. I was the one who suffered.

Thank you.

CHASE RIDGELY

TESTIMONY IN SUPPORT OF HB 1154 - HEALTH INSURANCE CONTINUATION

Ms. Cary R. Fenneman
11 Nightingale Way, Apt. C-7
Lutherville, MD 21093
Phone: (301)321-8610

I am a 56 year old Displaced Homemaker. For 23 years, until October 1981, I was covered under a Family health insurance policy through my husband's company. Six months after he left me I was dropped from his policy. I had been looking for a job since July 1981 without success. Being unemployed and very much in debt, I could not afford the high cost of individual coverage and so had none for the first time in my adult life. I just prayed I'd stay healthy.

In January 1982 I finally found employment with a Baltimore-based mutual fund company. I started as part-time temporary three days a week and was not eligible for medical coverage. In six months I was able to increase my hours to full-time, working over 40 hours per week. However, I was still classified as "part-time temporary" and therefore still ineligible for medical coverage. I asked if I could pay for my own medical coverage at their company rate, but was turned down flat.

I was still not in a financial position to pay for individual coverage.

I continued to work for this company another two years hoping to become a permanent employee which would have made me eligible for group health insurance. However, I was never offered a permanent position.

In April 1984 my position was phased out, and I was unemployed again until August when I found permanent employment and qualified for group health insurance with my present employer, at last.

I was very fortunate that I had no illnesses requiring medical attention during this almost four year period!

Thank you for this opportunity to testify on behalf of HB 1154. I am most appreciative for this chance for myself and the many others like me.

For: Hearing 2/27/85

JILL COLEMAN
5514 Roland Avenue
Baltimore, Maryland, 21210 (301)323-6235

Feb 27, 1985

TESTIMONY BEFORE THE ECONOMIC MATTERS COMMITTEE OF THE MARYLAND HOUSE OF DELEGATES

IN FAVOR OF HB 1154 - CONTINUATION OF HEALTH INSURANCE

When my husband divorced me I was 52 years old. I had been a traditional wife. I had not "worked" for 24 years. I was unemployable, recovering from the second of two back operations, paid for under my husband's group health insurance plan. Under a Voluntary Separation Agreement I received permanent alimony of 1/3 of his income, which he projected to be less than $72,000 a year. Thus I could count on less than $24,000 a year. I am extraordinarily lucky. I am at the very high extreme of the alimony scale.

As of the day before our divorce I was covered under a basic Blue Cross plan, and under a major medical policy at my husband's law firm. After I was dropped, a new insurer refused to honor existing conditions and also age-rated me. My major medical premium jumped from $180 per year to $383 per year--more than doubled. That's not so bad, but the deductible is $10,000 and I can't afford basic coverage. Let me tell you why.

Blue Cross, by whom I had been covered since I was 18 years old offered me basic coverage at $1700 per year! I just couldn't pay health insurance premiums of more than $2000 per year, one dollar out of every twelve I have.

But think about women older than I, living on $12,000, just above the poverty line as many older divorced women do, and with "existing conditions" more complex than mine. Under present law they may be charged as much as a fourth of their whole income just to get medical insurance!

It is too late to help me.
I did not want the insurance companies to subsidize me. But neither did I want to pay them $1500 in profit by the fact that I became divorced. And neither do I want to end up on the bad debt list of a hospital because I can't afford these staggering premiums. HB 1154 can help people like me without harming anyone else. I urge you to report it favorably.

101 Witherspoon Rd.
Baltimore, Md. 21212
February 27, 1985

Mr. Chairman and Members of the Economic Matters Committee:

I, Shirley Clifford, of Baltimore, Maryland wish to give testimony in support of HB #1154. I am affiliated with WISH (Women In Self Help), Turning Point (Essex Displaced Homemakers Program), Fair Family Law Association and am a counselor in private practice. However, today I wish to speak to you as a private citizen having recently gone through a divorce.

For twenty-five of an over thirty year marriage, I have resided in Baltimore City and have been a member of a group medical insurance plan through my ex-husband's employer. I have also been the primary insured as an employee for many years. Upon leaving employment, I felt it was necessary to avail myself of the conversion to individual coverage option offerred by the carrier. It was uncertain whether my husband would cancel coverage, without notification, under his policy at any time during the lengthy divorce proceedings.

Being unprotected by medical insurance would have been financially devastating for my family and me due to a chronic, life-threatening illness. This illness has required hospitalizations in the past and could again at any time in the future. Had I needed to rely solely on my individual coverage, for the payment of my last hospitalization, I would have been responsible for over $7000 worth of medical bills. My individual coverage was obviously grossly inadequate regardless of its being the best coverage I was offerred by the carrier. This inadequate coverage was "provided" for me at an annual premium of $1400.

These bills were eventually paid as coverage was maintained by my ex-husband's employer. Said payments took more than six months to be made, however, because my ex-husband had delayed forwarding of monies which he had received directly. Meanwhile I was being threatened with legal action by the providers. Attempts on my part to expedite resolution of these medical bills with the carrier met with refusal to discuss the matter with any but the primary insured.

Now that the divorce is final and medical insurance coverage has been included in the divorce settlement, I am still unable to ascertain the terms of the policy because I am not the primary insured. For instance, I do not know if a time limit for continuation exists nor do I know about deductibles, ceilings, or other possible limitations. I do not know if my college aged daughter is still included either.

I support HB #1154 as a means to reduce uncertainty and to provide dependent children and separated, divorced or widowed spouses maintenance of adequate and financially equitable insurance. I would be in favor of an amendment designating the separated, divorced or widowed individual as the primary insured. I urge you to report HB #1154 favorably out of your committee.

To the Maryland Legislature -

I was divorced in 1976 - after twenty-five years of marriage. Two of our children, then under eighteen remained on their father's Blue Cross - Blue Shield - Group Insurance plan - but I was dropped. I knew that it was imperative for me to have Health Insurance - so I began to inquire about any plan that would cover a single forty-five year old woman. I gathered all available information - But I was only eligible for non-group coverage - and I could not afford it.

I was teaching part time at two Private Schools, and asked if I could be included in their Health plans - but that was impossible. I asked my former husband if I could stay on his policy - but that was impossible. I am an artist, and I tried to get a group plan for the Art Society I belong to - but that was impossible. I explored with our Church secretary the possibility of forming a group, but that was not successful.

I couldn't believe there was no group plan for someone in my situation - so I wrote my Senator Rosalie Abrams for guidance. Her response was sympathetic but offered no answers.

Unfortunately that is where I was - and am. I had to take a non-group policy that offers much less coverage than I need - and still it is more than I can comfortably afford —.

Emily Tompkins Taliaferro

713 Stony Spring Drive
Baltimore - 21212, Md

ITEM 3

Letter to Senator Johnston From Mrs. Ruth Melancon
About Inability To Obtain Insurance

mrs. Ruth melancon
Born august 17 1927
age 57 next month
I will Be 58

mrs. Ruth melancon
[illegible] Valle St.
marrero La. 70072

I

Monday
July 1, 1985

Honorable:
Senator B. Johnson

Dear
Senator
I am writing to tell you about my medical Problems, We need help me want to live just like the People over 65.
I have high Blood Pressure I take hydro-diuril 50 mg Dr Baker once a day
I have high Chelosteral & [illegible]
hyperglycerdemia. Dr. Came for I quit the doctor Because I did not have the money I have to Be on a diet. Dr Bates
I have Cataracts in the eyes
I have a tubes on the eye lid.
I got hit in the eye left I cut it the eye I have varicose veins in the left leg. Big veins

II

I have arthusia in the foot
neck + wrist, I have Bladder trouble
I Cant it hardly go no where
I have Diverticulosis of the
Colon. I never no when my Bowels
will move I have hiatal hernia
I have Duodenal - diverticulum
of the Stomach.
I go to the mental Health
Clinic once a month Since 1970
my Family Dr. Bachr Said the
reason I get hurt when I try to
do Something is Because I am
too nervous.
I have muscule Spasm of the
left neck Dr. Klein I Break out with a
Big Ulcer on my tongue.

I Break out with Sores on my
Vagina. The doctor Says it is my
nerves Dr. Swanson
I have to take metamucil
twice a day for my Bowels.
for the rest of my life

you have to Pay on my house
to See the medicare Dr Bring
the medicade Card
only Pays for high Blood Pressure Pills

I get 318.00 V.A Widows Pension
+700 once a month 551.
I Can't eat anything Because
I get ~~diabetic~~ diarrhea
I have to Buy eye-drops
+ Special-water for my eyes
Because the eye lashes hard always
Falling in my eyes.

I Can't drink milk orange Juice
Coffee or anything with acid
I Break out in sores
~~Have~~ Right now I Can't hardly
walk Because arthritis Sent in my
foot, a nerve went in my foot in
the 1950's
when I want to go the grocery Store
I have to take Kaopectate, for
my Bowels I have to take a
Potassium Pill once a day
Because of the fluid I lode after
I take the high Blood Pressure Pill

1

Pretty Soon I will need ~~[illegible]~~ need
eye Glasses Because my Eyes are
TV very Bad.

not every doctor wants to
take the medicade card.
we need to get help like the
People over 65
they can get in a group insurance
while the medicare Costs $40.00
we can't.

we want to live too.

Sincerely

mrs. Ruth melancon
813 ello st.
marrero La. 70072.

This is just Some of my
Problems.

we need ye the doctor & I know
I have no insurance
my Blood Pressure Goes to
132 Low. Sistoli
107